State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.3 Table of Contents

1.4 Overview of the State

The Republic of the Marshall Islands is geographically in eastern Micronesia at 4-19 degrees North latitude and between 160-173 East longitude. There are 1,225 islands and islets in the Marshall Islands of which only five are single islands. The rest are clustered into 29 atolls of "rings" of islands that are interconnected and surrounded by coral reef. These 34 low-lying coral atolls and single islands are scattered over 750,000 square miles of the Pacific Ocean, and the total land area is only 70 square miles. Of the 34 atolls and islands, twenty-three are inhabited, and two of these atolls are considered as "urban" centers, and the rest as the "outer" atolls. Majuro Atoll is the capital of the Republic. Ebeye Island, located on Kwajalein Atoll, the largest atoll in the world, is the sub-district adjacent to an U.S. military missile-testing base located on Kwajalein Island.

The 34 atolls run roughly north-south in two nearly parallel chains about 150 miles apart and 800 miles long. The eastern chain is called "Ratak", meaning towards the sunrise, and the western chain is "Ralik" or towards the sunset. The atolls are narrow, low and encircle central lagoon. Most islands are less than 10 feet above sea level. Lagoons within an atoll range from three miles to over 70 miles in diameter.

People travel from Majuro and Ebeye to the outer atolls on a 24-seater Dornier managed by the Air Marshall Islands and on government-owned field trip ships that commute between atolls once a month. A small boat that is highly dependent on fuel supplies, availability of boats, and the weather must provide transportation within an atoll. If boats are not available, people walk during low tides on the exposed coral reefs between the islands in order to reach the airstrips.

According to the 1999 National Census of Housing and Population, the total population of the Marshall Islands is 50,840. More than 42% of the population is under 15 years of age. The average growth rate between the last census in 1988 and 1999 is 1.5%. Women in the 15-49 age range account for 12,235 or 24.2% of the total population. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% reside in the outer atolls. Delivery of health care services to a dispersed population in the RMI is cumbersome.

1.5 The State Title V Agency

The Constitution of the Marshall Islands designates the Ministry of Health and Environment (MOHE) as the "state" health agency. The MOHE is the only legislatively authorized agency that provides health care services to the people of the Marshall Islands.

The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health & Environment. It is responsible for all preventive and primary care programs throughout the Marshall Islands. There are six divisions with the Bureau of PHC, and the Division of Public Health is one of the five and the largest with five program areas.

The MCH/CSHCN Program is not a separate agency. It is one of the programs in Public Health. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provides health care services for mothers, children, infants, adolescents and their families in the RMI. There are currently 22 nurses who implement all clinical services for public health programs, seven medexes (physician assistants), a medical director and an OB-GYN who are assigned to Public Health. The same

nurses and medexes also travel to the outer atolls to implement the programs and services in Public Health. During the last year, the MCH/CSHCN program has been integrated into the Division of Population, Family Health, and Health Promotion. This integration will ensure that programs and services provided under MCH/CSHCN needs are enhanced and expanded to provide a more comprehensive range of services.

1.5.1 State Agency Capacity

The overall health care system in the Republic consists of two hospitals in the two "urban" centers of Majuro and Ebeye, and 60 health centers in the outer atolls. The main hospital on Majuro is an 80-bed facility, and Ebeye has a 25-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertiary care. Patients who need tertiary care are referred to hospitals in Honolulu or the Philippines. The Bureau of Primary Health Care within the Ministry of Health & Environment also offers a full range of preventive and primary care programs in the two main hospitals.

The MCH and CSHCN have been integrated into one program. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH. The RMI MCH/CSHCN program provides and coordinates the full spectrum of preventive and primary health care services for mothers, infants, children and adolescents both in the hospital setting and the health centers. The services include prenatal and high-risk prenatal care clinics, postpartum care, and well childcare that includes immunization, high risk pediatric clinics, school health program, coordination of family planning services, and the coordination of care for children with special health care needs.

In 1986, the government of the Marshall Islands adopted the concept of primary health care as declared by the World Health Organization in Alma Ata in 1978. The Bureau of Primary Health Care was established to target strengthening preventive programs and services at the community levels. It was necessary to reorganize and reorient the staff in primary health care in order to collaborate closely with the community leaders in implementing preventive and primary health care programs in the communities.

<u>The Fifteen Year Strategic Plan</u>

The government of the Republic of the Marshall Islands (RMI), through its Ministry of Health and Environment (MOHE), provides services which support good health and wellbeing at an affordable cost in an equitable manner. With limited resources in the RMI, distributed amongst competing sectors and demands, it is important to consider, broadly, what resources are available and how they are managed.

In terms of overall expenditure, there is neither a benchmark for what should be spent on the health system nor a methodology for determining what is low or reasonable cost. Compared to other pacific countries, RMI's spending on health is well above average.

The idea of the Fifteen Year Strategic Plan is to implement a dynamic plan which maintains continuity of policy, but a plan which is responsive to a changing environment and fluctuating resources, as well as allowing for flexibility to meet new issues and to adjust for under or over achievement of planned objectives.

In developing the Strategic Plan, the MOHE undertook a careful study of all its programs and activities, determined what it was trying to achieve, where it was placed in 1999, where it expected to be in the future and then determined how it was going to travel to that point. By setting down clearly defined goals and objectives, the Plan came into being. In addition, a Task Analysis for the first Five Year Plan in the Fifteen Year Strategic Plan was affected to identify the individual tasks which needed to be carried out in order that a strategy be fully implemented. Each task was allocated on a "by whom by when" basis to ensure that all MOHE staff clearly identify their responsibilities and by when these responsibilities need to be completed. They can, then, incorporate these tasks into their own Action Plans. In addition the task analysis gives supervisors and managers a tool which they can use to monitor progress and which will enable them to be proactive in ensuring that staff for whom they are responsible are performing the necessary tasks in a timely fashion. This task analysis became the Operational Plan.

Essentially, the major health problems in the Marshall Islands are lifestyle related. Most illness could be prevented through people living a healthier lifestyle. Simply put, a healthier diet and more exercise would result in less illness and a reduction in the need for health care provision. There is an unsustainable expectation for referral overseas (mainly to Hawaii or the Philippines) for treatment which is not readily available within the Marshall Islands. This expectation, if it continues to be realized will continue to drain scarce resources away from Primary Health Care, which is the chosen strategy of the Ministry in its delivery of health care.

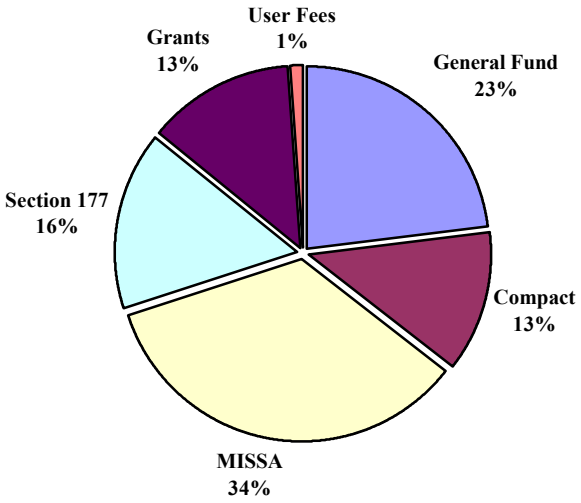
The Primary Health Care approach is based on the well established and well proven premise that the most effective as well as cost-effective health interventions are those pursued by individuals and families for the prevention of health problems before they arise. The prevalence of many life-style related diseases will diminish only when the population is educated and motivated to change behavior.

Health services need to be provided as much as possible within the islands. The burden of cost for referral care, restricts funding for more cost-effective interventions within the country.

The current economic situation within the Marshall Islands is not good, and the outlook is bleak. The Government is being forced to retrench on public employment in order to balance its budget and repay loans made against future revenue from the U.S. Compact. Most employment in the Marshall Islands has been a derivative of Government spending. As a result, economists expect a substantial fall in both Government revenues and total employment over the next three to five years. This means lower revenue from taxes and social insurance levies, and thus less money for the health service. With fewer jobs, the risk of malnutrition and diseases linked to poor nutrition will increase.

In the Financial Year 1999, the actual expenditure on Health was $12,612,907, with 34% coming from the Marshall Islands Social Security Administration (MISSA), 23% coming from Tax Revenue and only 1% coming from User Fees. More than 40% came from US Compact funds, Section 177 funds or US Federal Grant Funds. It is clear that there will be a continuing need for external funding for a considerable time to come.

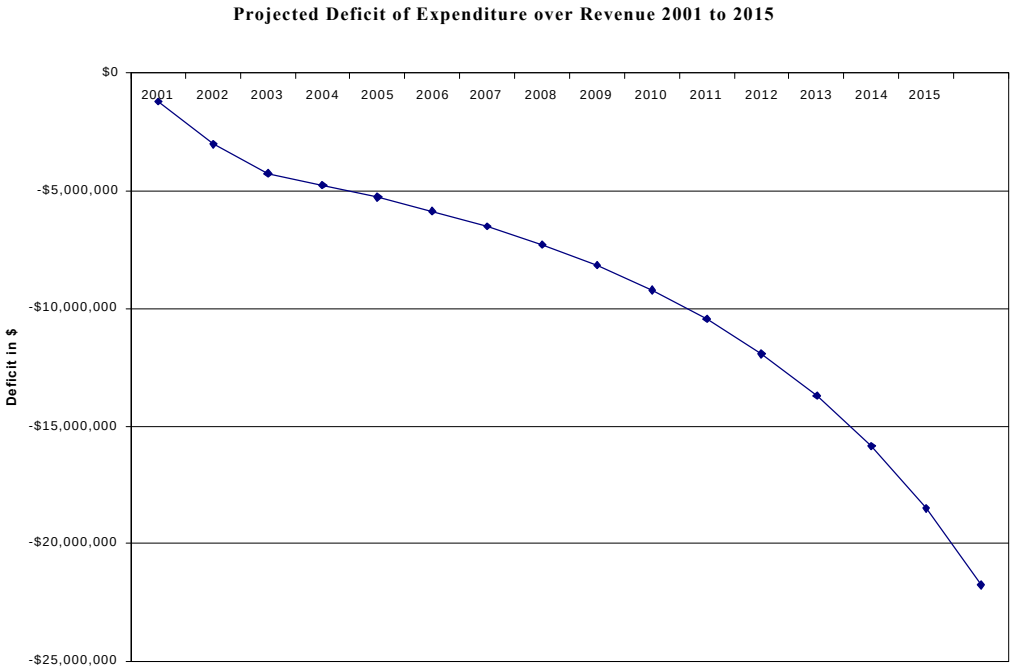
Proportion of Revenue by Source MOHE FY 1999



A Financial and Economic model has been created, which projects the costs associated with the implementation of the Strategic Plan over the Fifteen Years. The model has set out clear parameters for the projections and detailed the assumptions which have been made for the life of the Plan. As the plan is altered and developed over the years the spreadsheet containing the model can be updated and can be modified so that the projections will automatically be updated with the changes and modifications.

The Plan has bee set so that the goals can be achieved. The Plan aims to improve the health and wellbeing of all the people of the Marshall Islands, it aims to improve the scope, range and delivery of health services, but in setting the goals, the Ministry has adopted a pragmatic approach which takes into account the limitations and constraints within which MOHE staff have to operate. The Ministry has adopted a strict and responsible attitude in the light of the need for restraint dictated by uncertainty about future funding. It is hoped that the Plan can be developed and expanded as funding constraints are overcome.

Following is a graph which demonstrates the increasing deficit of Expenditure over Revenue projected for the life of the Strategic Plan.



Data Management

For several years, one of the priorities of the MOHE was to develop an effective health information system. Currently, the Ministry does not have a National Health Planner. However, under the Ministry's Health and Population Project that is financially supported by the Asian Development Bank, the Ministry has received technical assistance to modify its Health Management Information System (HMIS) in order to improve its capabilities to collect and use data to improve health care services. The Ministry has established a HMIS Committee and Working Group to review all forms and other documents that will enhance the HMIS. All programs in the Ministry have already started using the revised forms for recording and reporting of data which are being collected and channeled to the Bureau of Health Planning and Statistics. Staff training on the use of the revised forms is completed.

While data and information systems have improved in the past year, this improvement has occurred primarily within the urban health care settings. There is still a need to improve the data collection from the health centers in the outer atolls. The HMIS Committee has revised the recording/reporting forms, which will enable the health providers in the health centers to collect essential data and statistics. In addition to the encounter forms used by health facilities in the urban centers, a monthly form was developed to ensure that reports are regularly submitted to the Office of Outer Islands Health Care System office. The number of deaths and births in the RMI has been labeled as underreported by agencies within the Government due to inadequacy of reports submitted from the health centers. Therefore, mechanisms have been developed to improve the reporting of the number of births, deaths and encounters for all clinical and preventive services provided in the outer atolls.

The Health Management Information System (HMIS)

The HMIS is a computerized database designed to handle all health and health-related data in the MOHE. Based on the File Maker Pro software, it was designed to be a user friendly and menu driven system that can be used to monitor the progress of various health program, meet the reporting requirements of US Federal Grants, WHO, and other external agencies.

The HMIS has four goals that aim to meet the information needs in the RMI. The first goal is to support the expanded role of Primary Health Care. The Ministry believes that by implementing a wide range of effective and sustainable PHC programs, we can significantly reduce disease burden. Therefore data management and monitoring PHC is critical. The second goal is to provide accurate, consistent, and timely reports on the broad range of health services and programs offered by the MOHE. These reports can also assist health managers in decision making. The third goal is to provide the MOHE with a wider range of information on the personnel and financial resources that are available. This will assist in the health planning for the future. The fourth goal is to ensure that the HMIS is a sustainable system that can be used to provide timely and accurate data for managers tasked with policy making decisions.

HMIS Modules

The HMIS database is divided into five modules: Medical Records, Public Health and Epidemiology, Referrals, Finance and Personnel, and Benefits, Monitoring, and Evaluation (BME).

The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This information will be useful for clinical providers in treating the patients and to health service managers responsible for health planning, supervision and evaluation of health services.

Medical Records

The main focus of HMIS activities so far has been on the Medical Records component since it was where most of the data collected had to be consistent *and* able to accommodate *all* the curative and preventive care departments who see patients. Therefore, a comprehensive encounter form was developed.

The Encounter Form

The Outpatient encounter form contains the patient's name, medical record number, encounter date, date of birth, age, gender, atoll of residence, type of visit, and the health provider's name. A list of diseases classified by their International Classification of Diseases 9th Edition (ICD-9) codes, procedures, and referral destinations are listed in boxes for the health provider to complete.

The encounter form was originally designed for the hospital's outpatient activities. In collaboration with the HMIS Working Group, which comprised of the Secretary of MOHE, the Assistant Secretary, PHC, and various department and program directors, the original encounter form was modified and the name changed to "MOHE Encounter Form" to reflect the number of departments for which this form was redesigned. While it resembles the format of the original form, there have been numerous changes and modifications. The International

Classification of Diseases, 9th Edition (ICD-9) was used to standardize and classify patient findings. Sections of the form have also been rearranged to address the needs of each department. For the upcoming year, the encounter form will undergo a major overhaul integrating the recommendations and lessons learned from the two years it has been used. The redesign will make the form more user-friendly for the clinicians and data entry clerks who use it on a daily basis.

The MOHE Encounter Form is also being used in the Outer Islands and complemented with a monthly report form to be sent to Majuro each month by the Health Assistants. The MOHE Encounter already includes categories related to cancer screening and treatment. Combined with the patient's medical chart, the Encounter Form will assist both the clinician and the Ministry's data management and surveillance efforts.

Public Health and Epidemiology

The Public Health and Epidemiology component does not have a standard form (excluding those for Births and Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public health departments. This format will enhance monthly data reporting to the Planning Office and provide HMIS with the necessary information to assist in documenting vital and other health-related statistics. The data will enhance the data collected from public health and medical records. As part of the cancer screening and early detection program coordinator's duties, a monthly report will be sent to the Office of Health Planning and Statistics to ensure that the data is collected and appropriately disseminated. In order to assist in the improvement of data management particularly for the vertical programs in public health, standardized forms were created. These forms were designed for monthly and quarterly reporting to ensure that the ministry is able to maintain information that are timely, accurate, and current.

Referrals

The Referral component will be essential to determining the incurred costs for overseas referrals. Like the MOHE Encounter Form, patient information will also be included. The modules primary objectives are to document the amount spent on each type of referral. The patient and financial information can be used for long term planning. Through this module, the number of cancer related referrals to tertiary hospitals in the Philippines or Honolulu and cancer related deaths that occur overseas are documented.

Finance and Personnel

The Finance and Personnel Module was designed to provide the MOHE with a system that identifies financial information available and utilized by the Ministry. A Five-Year Budget Planning Model and Program Budget Allocation Program designed with the assistance of MOHE staff is being implemented to ensure that the services we provide are sustainable.

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relevance of the data we generate. In addition, the module is intended to provide a series of indicators to monitor and evaluate the efforts undertaken by MOHE staff. We will be able to see which health programs or services have had the most impact and which program needs refinements.

Training and Professional Development

The ministry and donor agencies fund the continuing education and training of public health staff. The assistant secretary or program directors assignment the personnel who attend training programs. The training has been in various formats like workshops, seminars, and certificate programs or academic programs.

Evaluation Plan

Monitoring and evaluation duties will be assigned to the individual program managers and directors and to the Bureau of Health Planning and Statistics. In the process of monitoring and evaluating the implementation of activities for the grant, the Health Management Information System is being tailored to address the needs of a database that will be flexible to collect epidemiological data that can be used as a tool for investigations and policy making decisions. Monthly reports from the various programs will provide significant data on the health services being provided and the types of cases seen in the clinical and public health offices. Data such as morbidity and mortality, number of cases seen involving fever, cases of diarrhea, number of chronic diseases like high blood pressure and diabetes will assist the Bureau of Health Planning and Statistics in identifying potential contributors to an outbreak. Preventive measures can then be taken to minimize the number of cases.

A formal evaluation will be done through the HMIS's Benefits, Monitoring and Evaluation module (BME). This module will complement other evaluation and monitoring tools that may be proposed by the Ministry's technical committee. The following table lists some of the measures that will be included in the BME.

Measure	Method of Determination	Data Source(s)
% Low Birth Weight babies	# low birth wt. Babies divided by total # live births	HMIS, Vital statistics
% pregnancies with first trimester care	# seen in first trimester divided by # of births	1. Periodic survey by public health staff 2. # initial prenatal visits in first trimester divided by # of births
Infant Mortality Rate	# infant deaths divided by # births	HMIS, Vital statistics
Child Mortality Rate	# deaths<age 5 divided by children <5	HMIS Vital Statistics, Census data or projections
Completed Child Immunizations	# completed immunizations divided by live births in previous 12 months	1. HMIS, outpatient encounter data, Vital statistics 2. Periodic sample of clinical records

Tetanus inoculations of pregnant mothers	# mothers vaccinated divided by number of births	1. HMIS, Vital statistics, OPD data, Hospital discharges 2. Program data (# inoculations)
Diabetes Controlled	% identified cases controlled	1. Population survey 2. Sample of medical records 3. Diabetes Program data
Pap smears	# women tested divided by # women age >14	HMIS (OPD), Census or population estimate
TB rate	Active TB cases per thousand	HMIS OPD encounter or TB program reports, census or population estimates
Active cases of leprosy (Hensen's Disease)	# active cases	Treatment register
Rate of GI illness	# cases of GI illness divided by total population	HMIS, OPD/Reportable diseases, Census or population estimates
STD rate	Reported cases of syphilis/gonorrhea divided by population age 15-64	HMIS, OPD/Reportable diseases, census or population estimates
Teen pregnancy	Pregnancies in population age 15-19	HMIS, Vital statistics, Discharge data, census/population estimates
Knowledge of family planning	% population age 15-19 with knowledge of modern contraception	Special or cluster survey
Contraception prevalence rate	% of couples using modern contraception	Special survey, census
Vitamin A Deficiency	% school age children with deficiency	1. Periodic survey by zone or public health nurses and health assistants 2. Sample survey
Breastfeeding	% at 4 months % at 2 years	1. Periodic survey by zone or public health nurses and health assistants 2. Sample survey
Suicides	# suicides per year in each age group	HMIS, Vital statistics
Dental sealant	# of children with molars sealed	Dental program data, Census or population estimates (outreach will not be possible until more staff is available)
Length of hospital stay	Total number days of stay	HMIS, Inpatient data,

	divided by total number of admissions	Discharge summaries, Medical records

These measures were selected to assist the Secretary of Health and Environment, Assistant Secretaries, department managers, program coordinators, and the Health Planning and Statistics Bureau in developing contingency, staffing, and organizational plans to ensure that the MOHE will have the means to collect and analyze data for tracking the National and Jurisdictional Performance Measures.

There have been several problems that have affected the ministry's data management as a whole. It has been frustrating since data that were easily obtained last year is difficult to obtain this year. Some of the problems identified have been the lack of trained staff to work as data entry clerks full time, the need of newer computers, lack of a functional computer network to enable data be readily available rather than solely relying on monthly reports, and the actual software used to program the HMIS database where there are no local expertise on-island.

1.5.1.1 Organizational Structure

The Government of the Marshall Islands has a parliamentary system. Thirty-three senators are elected to the Nitijela (congress) every four years, and from the Nitijela, a president is elected. The Presidential-appointed members of the Cabinet exercise all executive functions of the Government of the Marshall Islands. The Ministry of Health & Environment (MOHE) is one of nine governmental agencies instituted under the Government of the Marshall Islands.

The head of the MOHE is an elected senator and a member of the President's Cabinet. The Minister exercises executive authority for health on behalf of the Cabinet, and he/she is responsible for the development of policies for the Ministry with recommendations from the Secretary of Health and the administration of the MOHE. He/she is accountable to the national parliament in regards to the Ministry. The duties of the Minister are exercised as long as he/she is an elected senator or until the President re-appoints another elected senator to the post. The Secretary of Health and Environment, on the other hand, is appointed as the "permanent" head of the Ministry. The Secretary of Health is responsible for daily management and administration of the Ministry and reports directly to the Minister of Health.

The MOHE has five major Bureaus:

1. Bureau of Primary Health Care
2. Bureau of Majuro Hospital Services
3. Bureau of Health Planning and Statistics
4. Bureau of Kwajalein Atoll Health Care Services
5. Bureau of Administration, Personnel and Finance

With the exception of the Bureau of Health Planning and Statistics that is headed by the National Health Planner, an Assistant Secretary heads each bureau. All Assistant Secretaries and the National Health Planner report directly to the Secretary of Health & Environment.

The Bureau of Primary Health Care where the MCH program and CSHCN program is based, is further divided into six divisions:

1. Division of Public Health
2. Division of Human Services
3. Division of Population, Family Health & Health Promotion
4. Division of Adolescent Health
5. Division of Outer Islands Health Centers
6. Division of Dental Services

A director who reports directly to the Assistant Secretary for Primary Health Care heads each of the divisions. In the Division of Public Health, there are four program areas in which the MCH/CSHCN program is one. The Assistant Secretary for PHC is responsible for the daily management and supervision of programs carried out under the Title V program in each of the divisions.

1.5.1.2 Program Capacity

The 22 nurses and 7 medexes in Public Health including the OB-GYN and medical director provide comprehensive preventive services for all program areas in public health in the urban centers and for the outer atolls. The health teams from the urban centers travel on a quarterly basis to provide support to the health assistants staffing the health centers. When health teams travel to outer atolls, they conduct a variety of clinics, screening for MCH/CSHCN, TB/Leprosy, STDs, family planning, immunization, chronic diseases, and conduct health and nutritional promotion activities.

There are limited assistance programs available to mothers, infants, children, and children with special health care needs. Medicaid, WIC or other food supplements program, SPSDT, and federal vocational rehabilitation programs are not available in the Marshall Islands. While having a small pool of resources simplifies the coordination of tasks, the lack of resources available for clients hinders delivery of comprehensive services.

In the urban centers of Majuro and Ebeye, MCH/CSHCN services are provided in the Public Health clinics and further integrated in other programs such as the family planning, TB/leprosy and STD programs. All the programs in Public Health are conduct daily Public Health clinics and actively participate in community outreach activities. Public health teams weekly visit one of the health centers in the rural area of Majuro Atoll to provide a comprehensive MCH preventive and primary health care services. Zonal nurses who have been assigned to the seven zones in Majuro are in the field daily for screening, follow-up and providing needed preventive care services by going house-to-house. Nurses also refer patients from the zones to the Public Health clinics. The MCH services provided in Public Health include pre- and postnatal clinics, immunization, family planning, pap smear, STD screening and counseling, well child care and nutritional counseling. When a patient misses an appointment for prenatal clinics, the patient is referred to the zonal nurses who will locate the patient and bring her to the clinics. It must be noted that only seven of the nurses in Public Health are subsidized in the MCH Block Grant. In addition, the Block Grant pays the salaries for one OB-GYN, one health educator and a data clerk.

1.5.1.3 Other Capacity

Twenty-two nurses in Public Health implement all the clinical and preventive services for all program areas in Public Health. These same nurses travel to the outer islands in addition to supervising their assigned health zone in Majuro. The nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics and to immunize all new-born babies in the Majuro Hospital with BCG and Hepatitis B vaccines when necessary. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the cold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends.

1.5.2 State Agency Coordination

The Ministry of Health and Environment, being the only "state" agency that provides health care services in the Republic, realizes the significance of collaborating with other agencies in the implementation of services to the communities.

Since the MCH/CSHCN is one of the programs in Public Health, services are effectively coordinated among the staff in Public Health, who also provides services for other program areas. The MCH/CSHCN program also coordinates with other divisions in the Bureau of Primary Health Care, such as the Mental Health Program, Alcohol & Substance Abuse Prevention Program, Vocational Rehabilitation and Social Work. For community outreach purposes, MCH/CSHCN coordinates with the Health Education and Promotion Unit, the Nutrition Unit and the Family Planning Program. For FY 2000, this will be expanded to include other programs that provide services to the MCH/CSHCN population.

The MCH/CSHCN coordinator is also a member of the Inter-Agency Leadership Council which coordinates with all agencies that provide services for children with special health care needs. Through a Memorandum of Understanding, the members of the Inter-Agency coordinate services for all CSHCN and adults who have special needs. The members of the Inter-Agency Council include: Special Education Program in the Ministry of Education, Head Start Program, College of Marshall Islands, Majuro Atoll Local Government, Kwajalein Atoll Local Government, Women in Development Office in the Ministry of Internal Affairs, and the programs in the Ministry of Health & Environment such as the Mental Health Program, Vocational Rehabilitation and Social Work.

The Core Committee in the MOHE carries out coordination of community awareness on primary health care activities and programs. The MCH Coordinator chairs the Core Committee with other members from Nutrition Program, Hospital Services, Adolescent Health, Health Promotion, Family Planning and the Human Services programs. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Inter-Agency Council and the National Population Coordinating Committee.

Some of the activities conducted during the year included organizing and participating in the World TB Day, National Health Month that coincided with World Health Day (April 7th), Breast Feeding Week, World Diabetes Day, World Food Day, World Population Day,

Immunization Week, Mother's and Father's Day Seminars, World AIDS Day, and the National Week for the Disabled.

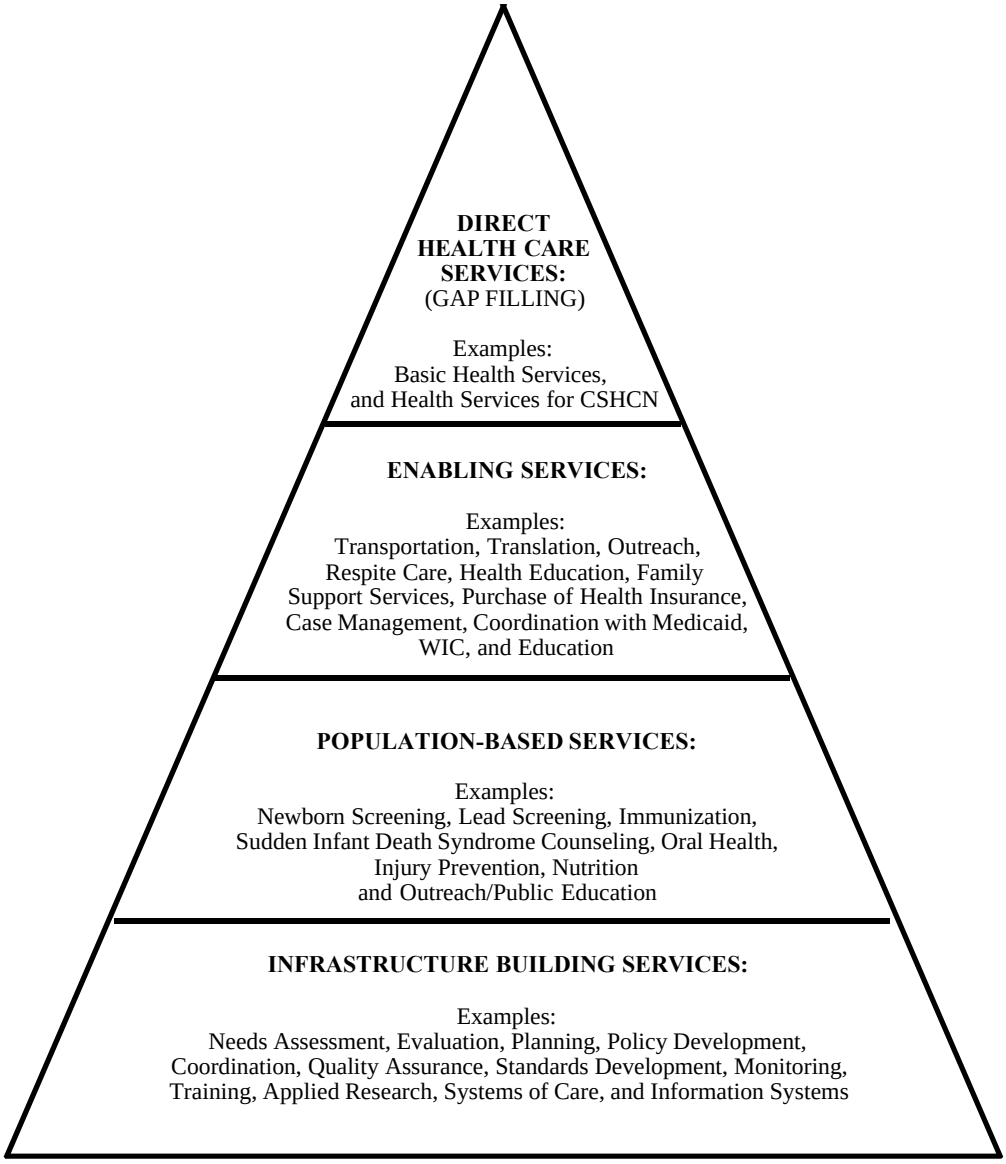
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

For FY 2000, the RMI spent 89% of its MCH funds. Fifty percent of the total grant award is for personnel. Of the total funds for non-personnel, the RMI spent 25% on direct health services, 11% on enabling services and 3% on infrastructure building services. The allocation of the administrative cost utilized 43% of its allocation. In FY 2001, the Ministry has been authorized to manage its own budget rather than the Ministry of Finance. This will enable the MOHE to better allocate and plan our services more efficiently and account for how the funds are utilized and expended more effectively.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

Details on Form 8

2.3 State Summary Profile

Details on Form 10

2.4 Progress on Annual Performance Measures

Direct Health Care Services:

Pregnant Women: For FY 2000, there were a total of 1,421 first visits to the prenatal clinics in Majuro with an increase in the visits that occurred during the first and second trimesters. This is an improvement from the past where 50% of the prenatal visits occurred in the third trimester. Heath education and promotion activities have targeted pregnant women and women of child breading age to attend prenatal clinics during their first trimester since expectant mothers in the past have attended their first prenatal clinics in the second or third trimester of their pregnancy. For the outer islands, the health assistants see the pregnant women. However, not all the women have access to prenatal care because of the cultural barriers. Except for three, all the health assistants in the outer island health centers are males. Women who are related or 'family' of the health assistants cannot access services for prenatal, family planning, STD counseling or even delivery. In cases like this, the traditional birth attends (TBA) are utilized for delivering of babies.

Prenatal Care Visits

	1996	**1997**	**1998**	**1999**
Total live births	1500	1601	1650	1,588
Prenatal visits in the first trimester	186	401	546	554
% of babies born to women with first trimester prenatal care	15%	25%	33%	37%

Source: Health Planning and Statistics, MOHE

Mothers: During prenatal visits, expectant mothers are screened for STD and HIV. Tetanus shots are given during first visits. Other health care services that are provided include dental check up, Pap smear, nutrition counseling and family planning counseling and registration for family planning after delivery. Teen mothers and mothers with health problems such as heart problems, diabetes, etc. are considered as high-risk cases. These cases have a prenatal high-risk clinic for close follow-up.

Teen (15-19) Pregnancy

	1996	**1997**	**1998**	**1999**
Total live births	1500	1601	1650	1,588
Number of teen pregnancies	264	260	291	328
Total live births x 100 =%	17.6%	16.2%	17.6%	20.6%

Source: Health Planning and Statistics, MOHE

Prior to 1995, the teenage pregnancy rate was 22%. With aggressive health education programs and collaborative efforts of all programs in the Ministry, including the National Population Coordinating Committee and family planning, the rate has decreased to 16.2% in 1997, a slight increase of 17.6% in 1998, and a jump of 20.6% in 1999. Unlike 1997 in which 2 maternal deaths were reported, 1998 only had one maternal death bringing the maternal mortality rate to 51 per 100,000. However, there were no maternal deaths in 1999.

The zonal nurses who conduct community outreach daily in the zones refer the pregnant women to the prenatal clinics in Public Health. When the women do not show up, the zonal nurses will follow-up at home. Sometimes it is necessary for the nurse to provide transportation to bring these women in for prenatal care. During prenatal visits, the women are given an appointment slip for the next visit and the appointment dates are logged. When the expectant mothers do not show up, the case is again referred to the zonal nurse who will get in touch with the mother to make sure she comes for prenatal care.

Infants and Children: Low Birth Weight (LBW) babies remain a problem in the RMI. In 1995, the percent of babies with low birth weight was 10.4%. In 1997, the percent has increased to 14.82% and the percent of very LBW babies was 0.33% for the same year. However, in 1999, the percentage of LBW babies dropped to 11.6%.

Low Birth Weight Infants

	1996	**1997**	**1998**	**1999**
Total # of Registered Births	1500	1601	1629	1,588
Total # of live births with known weight	96.27%	94%	94.4%	1,535
Percent of LBW babies	14.75%	14.82%	14.2%	11.6% (166)
Percent of very LBW babies	NA	0.33%	0.25%	0.14% (2)

Source: Health Planning and Statistics, MOHE

The Public Health nurses saw more than 4,500 infants and children under 5. The infants and children were seen at the well baby clinics, visits to the maternity ward, community outreach activities in the zones, and postpartum. Health care services for infants are provided through the weekly postpartum clinic, in which the two-week old infant is brought in for follow-up. After four weeks, the infant and the mother are seen together during the postpartum clinic for physical examination and immunization for the infant (family planning services are offered for the mother). Weekly well-baby clinic is also conducted in the Public Health clinics after the initial visit.

Aside from the well-baby clinics in Public Health, the nurses in the urban areas distribute Vitamin A twice a year to all the children under five years. This is done by going house-to-house. School children receive their vitamin A from the schools. Children who live in the outer islands receive their vitamin A from the health assistant. In FY 1997, a total of 14,205 infants and children received vitamin A. Out of the 14,205 there were 8,384 students who received both Vitamin A and de-worming medicines.

Immunization Coverage for under 2 years

	1996	1997	1998
# of 2 years old who have basic immunization series against:			
DPT (3)	1,458	1,171	3,564
OPV (3)	1,326	1,184	3,571
HBV (3)	1,047	1,036	2,287
MMR (1)	1,114	1,034	1,500
BCG (1)	1,458	1,397	1,547
# of two year olds with complete immunization series according to WHO guidelines	48.4%	75%	81%*

Source: Immunization Record, Majuro

*Number is based on total number of 2 year olds who have completed basic immunization series divided by the estimated population of children up to 2 years old.

The Immunization Program extended its coverage area to include children up to 9 years old. In 1998, a total of 13,710 vaccine doses were administered under the Immunization Program with 1,811 doses or 13.2% for children 3 to 9 years old.

Screening for school children is conducted by the staff from Public Health as coordinated by the Special Education Programs in the Ministry of Education and the Head Start Program. Children who are identified with abnormal findings are referred to the MCH/CSHCN program for follow-up.

Note: At the time of writing data for immunization has not been finalized and verified for the 1999 report.

Children with Special Health Care Needs: Infants who come to the postpartum clinics are screened for abnormal findings and those found to need special health care are referred to the MCH/CSHCN program. The nurses who conduct house-to-house community outreach also screen the infants and refer accordingly. The same nurses who travel to the outer atolls conduct screening during these trips. The members of the Inter-Agency Council, such as the Head Start Program and the Special Education Program, do coordinate with the staff in MCH/CSHCN program for regular physical examinations of these children. For FY 1999, 85% of the babies born were screened during postpartum visits.

The MCH/CSHCN program was able to utilize medical specialists who travel to the RMI. When the Ministry brings specialists to the islands, the hospital medical staff coordinates with the MCH/CSHCN program to ensure the registered clients and those in the schools are seen by the specialists. Some of the registered cases in the CSHCN program live in the outer atolls. The MCH/CSHCN program provides for transportation for these clients to travel to the urban center to be seen by the specialists.

Total number of registered children with special health care needs 1997 - 1998.

Type	1997	1998
Small for gestational age	52	43

Large for gestational age*	NA	50
RPR+*	NA	6
Premature babies	32	48
Congenital abnormalities	7	5
Cardiac problem	1	
1 or 2 eyeball missing	2	1
Anencephally	1	
Congenital cataract	1	
Hydrocephallus	1	
High arched palate	1	
Extra digits		1
Cleft lip		1
Cleft lip, cleft palate		1
Not stated in Medical Record		1

Source: Maternity Logbook and Nursing Reports
*Recently added for FY 1998-99

Total number of registered children with special health care needs: 1999

	1999
Ear problems	9
Burns	4
Cleft lip/palate	4
Syndactyly	1
Urogenic bladder	1
Cardiac	1
Joint abd bone deformity	12
Esophageal stricture	1
Congenital spine deformity/scolirsis	1

CSHCN Management

Category	**Number**
Referred to Shriners Hospital (HNL)	16
Other off island (Manila,HNL)	2
Managed on island	15
Waiting for treatment	1

Enabling Services:

Pregnant mothers: For the urban centers of Majuro and Ebeye, community outreach is done on a daily basis. The urban centers have been divided up into zones and two to three Public Health nurses are assigned to one zone. The zonal nurses are the same nurses who conduct the Public Health clinics in the morning, and in the afternoon, they are out in the field in their own zones. The services provided by the zonal nurses include screening for

TB and leprosy, referral for prenatal care services, nutrition counseling and follow-up with mothers who miss their appointments for prenatal care.

For the outer atolls, health teams visit these communities on a regular basis. A health team from the urban center of Majuro consists of a medex, who is the team leader, a health educator, dental nurses (usually two of them), a staff from the Mental Health Program, and two nurses who can provide services in family planning and immunization. Pap smear and screening for STD, TB and leprosy are also conducted during these trips to outer atolls in addition to follow-up with cases in each community. Health education and counseling is conducted during general clinics in each community.

Mothers: One-on-one counseling is provided to mothers who come to the Public Health clinics and for those who are seen at home by the zonal nurses. Nutrition counseling is provided to all mothers who come in during clinics and during community outreach in the zones. The nurses provide counseling to mothers who are identified as high risk, and those who are referred from the pediatric wards with malnutrition. Update on immunization services is also provided if necessary.

A Public Health nurse may use the MCH vehicle or any of the ministry vehicles to bring in the mothers who cannot afford to visit the clinics in Public Health. Public Health nurses coordinate their own community outreach programs in their own zones with the traditional leaders or landowners. It is more effective to involve the traditional leaders during planning of any community outreach activities, because the traditional leaders are more respected for their roles. Most people will participate in any community outreach programs when the traditional leaders provide support to do so.

Children: The MCH/CSHCN program provides transportation for all children with special health care needs from outer atolls who need to come to the urban center for regular follow-up. Scheduling for regular check-ups and follow-up are done by the nurses in the MCH/CSHCN program. Transportation is also provided to all those children who live in the urban center to the Public Health clinics and to the hospital to be seen by specialists from overseas.

Population-Based Services:

Pregnant women: Some of the services provided for pregnant women include pap smear, dental services, family planning counseling, nutrition and breast feeding counseling and vaccination for tetanus. Screening and treatment for STD are also provided, but not Hepatitis B.

Children: Population-based services were provided for all children who come to the clinics for newborn, well baby, high risk and children with special health care needs. The same services were provided for those children who are seen at home by the zonal nurses. The children who live in the outer atolls received population-based services from the health assistants.

Children with Special Health Care Needs: A total of 16 children with special health care needs were referred to the Shriner's Children's Hospital in Honolulu for further treatment

and follow-up. In addition, children were also referred to other hospitals in Honolulu and Manila. Since there are no local specialists who can provide the needed services for each of these children, services were provided only when specialists are brought in from hospitals outside the RMI. However, because of the effective collaboration between the medical staff and the MCH/CSHCN program, population-based services were provided to all children including those in the CSHCN program.

Infrastructure Building Services

Children with Special Health Care Needs Program: The CSHCN program seemed to have been in operation on its own for quite sometime. Prior to 1994, the program was coordinated with other programs such as the Vocational Rehabilitation and Special Education in the Ministry of Education. Although there were somewhat coordinated efforts to target those CSHCN, the MCH program was operating on its own. In 1994, with the new restructuring of the Bureau of Primary Health Care, the services provided under the MCHBG became known. Attempts were made to improve the services, coordination of services, data collection and to integrate services with other programs in Public Health in order to utilize all nurses and medical personnel for MCH. A committee was established to review the protocols for CSHCN. The committee was also given the responsibility to review all the cases that were referred and registered in the program and make recommendations for follow-up and evaluation.

There are still a lot of problems in the program. The program itself cannot be on its own with its own staff to implement the services. With the limited human resources, it is imperative that staffs are trained in all aspects of Public Health services to become "multi-skilled" medical staff. All staff must understand all programs in Public Health so they can provide the services that is needed in the clinics and in community outreach programs. Data collection remains a constraint, not only in MCH, but also for the Ministry as a whole. With the implementation of the Health Management Information System, the Ministry will be able to readily access and provide essential data and statistics.

In the coming months, the Ministry will continue to make changes in its organizational structure based on the availability of funds, human resources and the types of health care services that is affordable and accessible to the RMI population. Services for CHSHC will also be addressed in the restructuring of programs and services in the coming years.

There are no services provided in the RMI for Medicaid, Supplemental Security Income Program (SSI), Ryan White and Title IV AIDS programs, CASSP, developmental disabilities, and WIC. Programs and services for CSHCN are well coordinated with the Ministry of Education for the special education program and College of the Marshall Islands for Part H. The MOHE provides services for mental health, vocational rehabilitation, SSDI and MCH/CSHCN.

Performance Measure 1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN).
Accomplishment: This National Performance Measure is not applicable to the RMI since there is no SSI program.

Performance Measure 2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.
Accomplishment: The RMI scores an 8 on this performance measure. The RMI MCH/CSHCN provides for all of the services listed except for respiratory services. Medical and surgical subspecialty services are provided off-island. The RMI has access to additional medical specialties off-island. Patients needing specialized care are referred to Honolulu or Manila.

Performance Measure 3: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home".
Annual Performance Objective: 100%
Accomplishment: The Ministry of Health & Environment, being the "state" health agency, provides medical health care services to all residents through the State Hospitals on Majuro and Ebeye and in the Division of Public Health. All infants who are identified are referred to the pediatricians or the physician on call, who will become the primary physician for the referred case. The MCH/CSHCN program collaborates closely with the medical staff in the Majuro Hospital and Public Health in providing the services. Every child that is referred is considered as having a "medical/health home". All children seen in the rural areas (i.e. outer islands) are seen at one of the 60 health centers and are referred to either Majuro or Ebeye if secondary care is required.

Performance Measure 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies combined.
Accomplishment: This National Performance Measure is not applicable to the RMI since metabolic screening is not performed.

Performance Measure 5: Percent of children through age 2 who have completed immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemphilus Influenza, Hepatitis B.
Annual Performance Objective: 85% coverage rate
Accomplishment: This Performance Measure was not met. A major contributor to achieving a high coverage rate is the continuation of the zonal nursing program that proved successful in increasing previous years' coverage rates. The RMI was able to increase the coverage rate for children through age 2 who have completed their immunization series to 81%.

Performance Measure 6: The birth rate (per 1,000) for teenagers aged 15-17.
Annual Performance Objective: No more than 150 per 1,000
Accomplishment: The data for this performance measure cannot be specified since the age group in this particular category included teenagers 15 through 19. In Marshallese culture, 19 is still considered young and under age. Therefore, data collected includes those who are 18 and 19 years old. Of the 1,588 live births in 1999, 328 or 20.6% were from teenage pregnancies. In 2000, of the total 1,627 births, there were 315 births from teenage mothers (19.4%).

Performance Measure 7: Percent of third grade children who have received protective sealant on at least one permanent molar tooth.
Annual Performance Objective: 95% of the proportion of children ages 8 and 14.
Accomplishment: The RMI did not meet this objective. Like 1997 and 1998, the School Sealant Program was not implemented due to the limited number of staff in the Dental Services.

Performance Measure 8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.
Annual Performance Objective: no more than 5 per 100,000
Accomplishment: According to statistics data, there were 4 deaths that occurred to children aged 1-14 due to motor vehicles crashes. While other causes of deaths such as malnutrition, pneumonia, congenital heart diseases and drowning, are more common, motor vehicle-related accidents are a growing concern.

Performance Measure 9: Percentage of mothers who breast feed their infants at hospital discharge.
Annual Performance Objective: 95% in early postpartum
Accomplishment: Since the introduction of the Breast Feeding Policy for the Ministry of Health and Environment in 1996, the percentage of mothers who breast feed their infants upon discharge from the Majuro Hospital is 98%. The percent of mothers who continue to breast feed their infants up to six months is 95%. This data does not take into account babies put up for adoption who are not breast fed by their birth mothers when discharged from the hospital.

Performance Measure 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.
Accomplishment: This National Performance Measure is not applicable to the RMI. The newborns are not screened for hearing impairment before hospital discharge.

Performance Measure 11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.
Annual Performance Objective: 100%
Accomplishment: The Republic of the Marshall Islands has a unique health insurance policy whereby all Marshallese are covered by the state medical insurance. Medical services are provided to all residents from the Ministry of Health & Environment, which includes the two hospitals in the urban centers and the health centers in the outer atolls.

Performance Measure 12: Percent of children without health insurance
Annual Performance Objective: 0%
Accomplishment: Please refer to Performance Measure 11

Performance Measure 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
Accomplishment: This National Performance Measure is not applicable to the RMI, since there is no Medicaid Program.

Performance Measure 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.
Targeted Objective: 10
Accomplishment: In 1998, the RMI scored an 8 for this particular performance measure. The RMI completely met for family members participate on advisory committees or task forces and are offered training, mentoring and reimbursement, when appropriate, partially met for financial support is provided only for travel and child health care services but not other categories, partially met for family members are involved in the CSHCN elements of the MCH Block Grant Application Process, partially met for family members are involved in inservice training of CSHCN staff and providers, and partially met for family members of diverse cultures who are involved in all of the above activities. Despite the improvements of this past year, the RMI is still unable to achieve its target of 10.

Performance Measure 15: Percent of very low birth weight live births.
Annual Performance Objective: 5% of live births
Accomplishment: This performance measure was almost met. In 1998, the total number of registered live births was 1650 of which 4 or 0.25% accounted for very low birth weight babies (VLBW) and 14.2% was low birth weight (LBW) babies. In 1999, 2 of 1,500 live births or 0.1% accounted for VLBW babies.

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths 15-19.
Annual Performance Objective: 50% decrease from the current rate
Accomplishment: The RMI met this objective in 1999. The number of teen suicides that occurred in 1996 was 9. The number was increased to 12 in 1997 and 1998. According to the Division of Human Services, there were a total of 5 completed suicides for 1999 with no cases in the 15-19 age group.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
Accomplishment: This National Performance Measure is not applicable to the RMI since there are no facilities capable of providing specialized services for very low birth weight infants.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
Annual Performance Objective: 30%
Accomplishment: This Performance Measure was met. **For 1999, there were 554 or 39% of infants born to mothers who received prenatal care in the first trimester.** There were a total of 1,421 prenatal vists. This is a significant improvement compared to 1997 and 1998 when the total number of women who began prenatal care in the first trimester accounted for only 25% and 33% of the total live births respectively.

The RMI has selected the following State Performance Measures. These measures have been selected to address the levels of services provided under the Title V MCH Block Grant and the areas identified by the MOHE as priority areas. The State Performance Measures that are italicized were discontinued. Changes were made based on the FY 1999 MCH Title V Block Grant Review Report.

State Performance Measure 1: The percent of mothers who receive counseling on nutrition and family planning during prenatal visits.

Annual Performance Objective: 90% of prenatal visits

Accomplishment: This objective was met. All pregnant mothers who come for prenatal care received counseling on family planning during the first visit. Counseling and registration for family planning was also done in the follow-up upon delivery and again when the mother comes back for postpartum clinic. Arrangements have been made to integrate nutrition counseling as part of the services provided to mothers attending prenatal clinics. With the integration of the MCH/CSHCN program into the Division of Population, Family Health, and Health Promotion, counseling services have expanded to include the provision of nutritional and family planning counseling services during prenatal visits.

State Performance Measure 2: The percent of pregnant women who receive prenatal care during the first trimester. **(DISCONTINUED*)***

Annual Performance Objective: 25% of pregnant women.

Accomplishment: **This measure was discontinued since it duplicates a national Performance Measure.**

State Performance Measure 3: Percent of Children under 2 years who have completed basic immunization series. **(DISCONTINUED)**

Annual Performance Objective: 75%

Accomplishment: **This measure was discontinued since it duplicates a national Performance Measure.**

State Performance Measure 4: Provide health education activities related to suicide prevention geared towards the 15 to 19 year old age group.

Annual Performance Objective: 25

Accomplishment: This State Performance Measure was not met. From the 30 documented activities performed by the Division of Human Services in the RMI, there were only 2 that were related to suicide in this age group. Compared to previous years' activities, health education activities on suicide have increased. The Division of Human Services, in collaboration with other agencies, organized the National Suicide Prevention Seminar that was attended by representatives from other island nations and regional organizations.

State Performance Measure 5: The percent of women who exclusively breast feed their infants up to six months of life and continue for up to two years.

Annual Performance Objective: 100% of infants.

Accomplishment: This State Performance Measure was not met. The Ministry of Health and Environment has carried out a Breast Feeding Policy in the hospitals where are infants must be breast-fed upon discharge. Data has shown that 90% of the infants who visit well baby clinics at six weeks are exclusively breastfed. The Ministry is still in the process to assess data collection on breast feeding practices up to six months taking into account the effect of infants put up for adoption where the babies are not breast fed. The ministry will be planning another survey to measure and progress of promoting breast milk over baby formulas.

State Performance Measure 6: The proportion of children 0-3 years old who are identified to need special health care are referred to the Children with Special Health

Care Needs Program. (Beginning FY 2001, "proportion" will be changed to "number")
Annual Performance Objective: 1
Accomplishment: This State Performance Measure was met. All the children identified to need special health care in 1999, all were referred to the MCH/CSHCN program. Data on screening activities has not been fully established. The screening element to identify children with special health care needs was not developed.

State Performance Measure 7: The proportion of women who are screened for cervical cancer (Beginning FY 2001, "proportion" will be changed to "number")
Annual Performance Objective: increase by 10%
Accomplishment: The objective was not met particularly in the number of women who received Pap smears during 1998 of 916 screenings was significantly lower than last year's 1,155 screenings. In 1999, a total of 1,146 pap smears were performed with 949 satisfactory smears. However, there is a need to improve the services provided in this area, especially to do follow-up after the Pap smears are done. Education on performing self-breast exams will continue to be taught to women who come for check ups and physical exams.

State Performance Measure 8: The proportion of school children between ages 8 and 14 who receive dental services. **(DISCONTINUED)**
Annual Performance Objective: 75% of school in urban center
Accomplishment: **This measure was discontinued due to shortage of dental personnel.**

State Performance Measure 9: The percent of high-risk pregnant women who are identified and are referred to special prenatal services. (NEW MEASURE)
Annual Performance Objective: 40% of pregnant women.
Accomplishment: This was a new State Performance Measure for 1999. However, due to problems encountered in the ministry's data management infrastructure, we are unable to provide accurate numbers for this measure.

State Performance Measure 10: Increase the number of teenager (15-19) acceptors of modern contraception. (NEW MEASURE)
Annual Performance Objective: 20%
Accomplishment: This was a new State Performance Measure for 1999. However, due to problems encountered in the ministry's data management infrastructure, we are unable to provide accurate numbers for this measure.

2.5 Progress on Outcome Measures

Outcome Measure 1: The infant mortality rate per 1,000 live births.
Annual Outcome Objective: 27 per 1,000 live birth
Accomplishment: Due to problems encountered in the ministry's data management infrastructure, we are unable to provide accurate numbers for this measure. The 1999 Census on Population and Housing estimates that the IMR to be 37 per 1000. This data is also being confirmed.

The RMI met this objective with an IMR of 25.25 per 1000 in 1998 compared to 1996 and 1997 when the IMR were 26 and 30 per 1,000 live births respectively. It must be noted that under reporting of births and deaths from the outer atolls remain problematic. In communities with less than 100 or 200 people, there are times when no babies are born within one year, because all the mothers are family planning users. Results from the 1999 national census, which are still pending, will provide a more accurate IMR next year.

Outcome Measure 2: This outcome measure is not applicable to the RMI.

Outcome Measure 3: The neonatal mortality rate per 1,000 live births.
Annual Objective Measure: 8 per 1,000 live births.
Accomplishment: This outcome measure has been met. In 1999, the neonatal mortality rate was 7.56 per 1,000 live births for the RMI. Prematurity was identified as the main cause of neonatal death. This data is preliminary at the time of writing.

Outcome Measure 4: The postneonatal mortality rate per 1,000 live births.
Annual Objective Measure: 22 per 1,000 live births
Accomplishment: According to statistical data, the postneonatal morthality rate is 4.41 per 1000 for 1999. The postneonatal mortality rate for the RMI in 1998 was 6.66 per 1000 and in light of a variety of problems encountered with some of the databases, the accuracy of the 1999 rate is being confirmed.

Outcome Measure 5: The perinatal mortality rate per 1,000 live births.
Annual Objective Measure: 30 per 1,000 live births.
Accomplishment: This outcome measure was met with a perinatal mortality rate of 14.56 per 1000. The main causes of the deaths include prematurity, birth complications, sepsis, congenital abnormality, cord accident or respiratory distress syndrome with prematurity identified as the main caused of death. In our efforts to decrease the rate of perinatal deaths, a perinatal meeting is conducted twice a year to evaluate and make changes to address any emerging issue.

Outcome Measure 6: The child death rate per 100,000 children aged 1-14.
Annual Objective Measure: 30%
Accomplishment: Due to problems encountered in the ministry's data management infrastructure, we are unable to provide accurate numbers for this measure. However, it is known that the main causes of death include malnutrition, pneumonia, tuberculosis, meningitis, suicide, congenital heart disease, motor vehicle-related accidents, and drowning.

Outcome Measure 7: Percent of families of CSHCN whose out-of-pocket medical expenses exceeded 5% of annual income.
Annual Objective Measure: 0%
Accomplishment: This outcome measure has been met as the result of the RMI's state health insurance policy whereby all Marshallese are covered by the state medical insurance.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The MCH/CSHCN program did not conduct a formal Needs Assessment for the programs and services provided for MCH. However, based on a Needs Assessment conducted by the MOHE, steps have been taken to address issues pertaining to the MCH population.

During the past year the Ministry has implemented the Fifteen Year Strategic Plan for 2001 - 2015. During the process, the Secretary of Health & Environment and the senior staff of the Ministry conducted program evaluations on services provided by the Ministry. A needs assessment was also conducted to identify program areas that need improvements so that the goals and objectives set for the next five years will be met. It was necessary to review all data and statistics and evaluate how the services are implemented based on the statistics presented. Furthermore, in the reviewing process, it was necessary to review the goals and objectives for each program area that receives federal grants to ensure the same goals and objectives are included in the Five-Year Health Plan.

The Assistant Secretary for PHC and the division directors meet twice a month to discuss programs and services in the Bureau of Primary Health Care. The Assistant Secretary and her immediate staff have the capacity to recommend changes in preventive services for all programs in the Bureau. With the approval from the Secretary of Health & Environment, changes and recommendations are carried out accordingly for all programs.

In addition, staff from the maternity ward, the two hospitals, Public Health, family planning, MCH, medical records and Health Planning have perinatal meetings twice a year to discuss perinatal deaths and make recommendations to improve services. Based on recommendations and results of these meetings by staff in the Ministry as a whole, the following issues were identified as areas that needed improvement.

- prenatal visits in the first trimester
- health education/nutrition education during prenatal clinics
- coordination of referral for CSHCN due to lack of understanding on the system by staff in Public Health
- screening tool for CSHCN during clinics
- high population growth rates
- low rates of family planning acceptors
- increase in teenage pregnancies
- increase in low birth weight babies
- nutrition counseling for CSHCN
- data collection and statistics in MCH and other programs
- programs and services addressing the teenage population
- dental services in the schools and lack of school health programs
- preventive services for women on Pap smears and follow-up

Although Enabling Services are provided to the MCH population, the issues presented here show that there is a need to improve the coordination of services, increase community

awareness and the involvement in the primary health care services and training of staff to coordinate better in providing services among and between programs, do a lot of educational activities at the community level and improve the collection of data in MCH. Coordination of services with other agencies is another area that must be improved in order to provide continuous health services to the MCH population.

The programs in Public Health have already initiated steps to address these issues by conducting a seminar with the traditional leaders in Majuro and Ebeyeto discuss these preventive programs and how the traditional leaders could support and implement PHC in their areas. Nurses who have been assigned to the zones have taken the initiatives to work closely with these traditional leaders in coordinating the community outreach activities.

Under the Infrastructure Building Services, steps have been initiated by restructuring the Ministry's organizational structure to strengthen coordination of services among and between programs in the Ministry. The Health Management Information System is now in its first year of implementation to improve recording and reporting of data and statistics in all areas. Refinements are continuously made to enhance the Ministry's data management capabilities. A Needs Assessment plan was developed for conducting the upcoming Title V Five Year Needs Assessment of the MCH and CSHCN population in FY 2001.

Needs Assessment and Action Plan for the Maternal Child Health Block Grant

The process of assessing the needs of the RMI's Maternal and Child Health population occurs year round. The health status and vital statistics indicators from the needs assessment database will be used to set priorities. The priorities will be consistent with state and national health strategies.

Many common indicators (i.e., death rates for infant and children, percent of births with low birth weight, percent with late or no prenatal care, etc.) will be used as many of these rates have been examined over multiple years.

Introduction:

The following is a general outline of the needs assessment methodology.

The Maternal and Child Health Program conducts various needs assessments year round. Updated data and information will be added when it becomes available.

The capacities of both the Bureau of Primary Health Care (includes Division of Public Health) and Hospital Services are being carefully analyzed. This analysis will create new and will extend existing relationships. This will result in a better use of databases and specific expertise in areas such as data analysis. All of which will result in more efficient use of available resources. The data collected by the different programs will be entered into the Health Management Information System (HMIS) so that it can be documented, analyzed, and disseminated.

Updates will be used to make appropriate adjustments in activities such as plan development, funding, quality assurance and standards development. Updates will also be used for reporting

and budget development. This database will allow better depth, breadth, and quality, as well as the identification and use, of new data resources.

Purpose:

The purpose of the Maternal and Child Health (MCH) Needs Assessment are as follows:

1. To provide a baseline and updated data for defining and redefining policy and future direction for MCH.

2. To provide a baseline and updated data for planning and allocating MCH resources.

Objectives:

The objectives of the MCH Needs Assessment are as follows:

1. To provide information and data to plan and implement services and programs that address local needs.

2. To identify the following:

    - Duplication, gaps, and service and/or program under-utilization.
    - Access barriers that clients encounter.
    - Issues and activities where technical assistance and consultation is needed.
    - Issues that require policy development.

3. To determine roles and responsibilities of each staff assigned to the MCH program.

4. To recommend strategies for assuring service availability and appropriate services delivery systems exist.

5. To acknowledge providers national impact on meeting local and national goals and objectives.

Methodology:

The nationwide needs assessment will be conducted in phases. These phases include:

Phase I: Organization of the planning project.

This phase includes establishing the purpose of the project, determining desired outcomes, assigning staff and defining roles.

A. Define the target population:

The target population is the group(s) of individuals about which the information for the Needs Assessment is desired.

- All pregnant women in a given year.

- Mothers and expectant mothers.
- Infants less than 1 year.
- Children aged 1-22 (including CSHCN).

B. Organize a planning group:

To adequately address the needs of the population, individuals must be identified who represent the varied interest of the population and professionals who can provide valuable information and expertise.

- Representation from external groups (i.e., Special Education, Public Safety, Church Groups, Traditional Leaders, NGOs, etc.)
- Service providers from within the community (i.e., Private providers, schoolteachers, etc.)
- Service providers from within the health system (i.e., Public health providers, nurses, etc.)
- Consumer representatives (i.e., Parents, teens CSHCN's and parents of CSHCN)

Responsibilities of the planning group include the collection of data; prioritizing the identified needs; developing the Annual plan which addresses the problems that are identified.

C. Review the scope of the MCH Needs Assessment:

- Review and refine the assessment tool.
- Assign roles and responsibilities of the planning group.
- Determine the commitment of time and resources.

D. Identify and commit resources:

- Communication - to maintain the collaborative process.
- Staff time and community participation.
- Health status data.
- Staff to analyze data.

E. Plan Data Collection:

The data needed to satisfy the assessment should reflect all dimensions of child and family health.

- Primary data - this refers to data collected for a specific Needs Assessment.
- Secondary data - refers to data collected from existing sources (i.e., HMIS, Census data, Vital Statistics, health-related data and data collected from disease registries)

F. Identify and assess needs:

Determination of needs requires a value judgement. The identification of needs is a process of describing and prioritizing the problems of the target population and recognizing potential solutions to those identified problems.

- Normative Need - derived from expert opinions about appropriate levels of service or health status. These are often standards (i.e. Healthy People 2000 objectives)
- Perceived Need - derived from the expectations of the population.
- Expressed Need - defined through the utilization of services.
- Relative Need - derived from examination of the equity of distribution of services across populations.

Phase II: Data collection:

The second phase is the collection of the information to set the scope and help prioritize the issues. A questionnaire will be used for this phase. The questionnaire will be designed to provide information about the positive aspects of the current service delivery system, what areas need improvement or change, and the desired outcomes from providing family-centered, community-based, coordinated services to children with special health care needs and their families.

Phase III: Briefing Paper:

This phase involves the development of briefing papers examining the prioritized needs in details. The planning group will use the papers as the basis for discussion.

Phase IV: Draft Report:

This phase is the processing of all the collected information and incorporating the comments regarding the briefing papers into a draft report. The report will describe the current service delivery systems, and the views of families, service providers, community members and representatives of governmental agencies.

Phase V: Hearing:

The distribution of the draft report and holding public forums for comment on the report and to hear additional views regarding the systems of comprehensive and coordinated care.

Phase VI: Final Report:

The completion of a report that includes written comments and input from the public.

Phase VII: Strategic Plan:

The development of a strategic plan for implementing necessary service changes or improvements as determined by the Needs Assessment. The process for developing the strategic plan will be dependent upon the results of the previous phases.

Time Line:

Phase I:	**Organization of the planning project.**	**January & February**
Phase II:	**Data collection:**	**March**
Phase III:	**Briefing Paper:**	**April**
Phase IV:	**Draft Report:**	**April**
Phase V:	**Hearing:**	**May**
Phase VI:	**Final Report:**	**June**
Phase VII:	**Strategic Plan:**	**June**

3.1.2 Needs Assessment Content

There was no formal Needs Assessment conducted to evaluate the services provided to the MCH population. However, based on an assessment conducted by the MOHE utilizing data from the Health Planning and Statistics Office, it is clear that MCH services and primary health care services must be further improved in order to improve the health status of the MCH population. The RMI has selected the Seven State "Negotiated" Measures that will address the four layers of the pyramid, namely direct health care services, enabling services, population-based services and infrastructure building services. Additionally, the selected "negotiated" measures will further support the Core Public Health Service outcome measures.

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The Marshall Islands is characterized by:

1) a very young population
2) high growth rate
3) high fertility rate
4) high teen pregnancy
5) high infant mortality rates
6) low immunization coverage
7) low family planning acceptor rates

These are all indicators that the MCH program and services must challenge each year.

Data compiled by the Bureau of Health Planning and Statistics show the very high rates of cancer in the RMI, particularly for women. The RMI has very high rates of cancer than any other Pacific country. It is essential that preventive services for women be further improved to have women access the services. Combined with health education and promotion activities and counseling, accurate and timely reporting of Pap smear results will improve the early detection of reproductive cancers particularly cancers of the cervix and uterus.

<u>Rates of cancer cases and cancer related deaths in the Marshall Islands</u>

Year	Death (all causes)	Cancer (all types)	Cancer, Reproductive
1991	209	19	5
1992	209	18	7
1993	241	28	6

1994	247	32	12
1995	245	25	11
TOTAL	1151	122	41

Bureau of Health Planning and Statistics

Mortality Related to Reproductive Cancer in Women, 1995-98

Cause of Death	1995	1996	1997	1998
Cervix	9	6	6	4
Breast	0	2	2	2
TOTAL	9	8	8	6

Bureau of Health Planning and Statistics

3.1.2.2 Direct Health Care Services

In the two urban centers of Majuro and Ebeye, direct health care services is very much accessible. The number of medical staff is adequate to enable the MOHE to provide health care services to the population. Maternal and child health care services are provided weekly in the Public Health clinics. Community outreach programs are conducted daily in the zones and weekly in the distant health centers in Majuro. Although there are only 18 physicians in the hospital and Public Health, people who live in the urban centers have the privilege to choose their physicians in the out-patient clinics.

Public Health clinics are held in the mornings in the outpatient clinic area. Outpatient clinics are conducted in the afternoons. Medical staff in the hospital are the same doctors who take care of the in-patients, assign to the Emergency Room, and are on-call even on weekends. In our efforts to improve follow-up with patients after discharge and also to better utilize the limited number of physicians in the Ministry, the medical staff in the hospital also participate in the Public Health clinics in the mornings after their regular 'medical rounds' with their in-patients.

Screening for STDs and other infectious and communicable diseases is carried out in the two main hospitals for in-patients, outpatients and public health clinics. Treatment is provided to all patients after pre- and post-test counseling. The nurses conduct well baby clinics weekly and regularly in the zones. A child who is admitted in the hospital for malnutrition is referred to the Social Work staff who visits the pediatric ward daily. Family planning services are accessible from the family planning staff and clinic. Pap smear is done in some of the public health clinics, depending on the availability of laboratory supplies. However, not all the staff in the laboratory can read pap smears. Only one staff is capable of reading the pap smears making it necessary to send pap smear slides to other laboratories outside the RMI.

For the outer atolls, the situation is distinctive. Direct curative services is accessible in the health centers. Other preventive services are also accessible such as prenatal care, family planning services and immunization programs. However, there is only one health provider (the health assistant) in the health center. The people in a small community do not have the choice for their health care services. The women are the most disadvantaged, because of the cultural barriers that inhibit them from accessing health care, particularly for maternal

health, and family planning. In all the health centers, except for two, the health assistants are males. Marshallese society has a very close knit culture where the extended family plays a central role. In this respect, if a woman is related or 'family' to the health assistant, she cannot access prenatal care or even family planning services. Women can have pap smear in the outer islands only when the health team visits, or if they come to the urban center.

Electricity is not available in all but one of the outer islands. Therefore laboratory services for STD, simple hemoglobin tests or pregnancy tests, pap smear reading are not provided in the health centers. Immunization programs are conducted only when the vaccines are sent to the health centers. It is necessary to inform the health assistant by radio when the cold chain boxes are delivered so the children in the community can be vaccinated immediately to avoid damage to the vaccines. When the vaccines are used up (usually after one day), the cold box is sent back to the urban centers with the report.

For the children with special health care needs who live in the outer islands, limited services in provided in the health centers. The CSHCN do receive services for immunization if the vaccines are accessible. The health assistant is not capable of providing medical consultation and evaluation without proper equipment and supplies.

3.1.2.3 Enabling Services

The same situation applies for the services under this category. Health education is conducted by the staff in the unit. Health education staff use the government-owned radio station to air the weekly health education radio program, air radio spots and announcements, and health promotion messages. Additionally, articles and news spots are submitted to the only one newspaper for the entire country to be printed in the health column. All newspaper articles and radio announcements are written in Marshallese. During health campaigns, it is more effective to distribute announcements through government officials and offices to ensure government employees are aware and support of health activities. The same announcements will be announced on the radio.

People in the outer islands may not have access to a radio. However, those families who have access to a radio do share the news with the rest of the community members. In the urban centers the situation is different. Most people have access to a radio, and a television set. However, not all people do listen to the radio. So health education utilizes both means to ensure the public is informed on health care services. Transportation from one island to another is a barrier in the outer atoll, and even between the outer islands and the urban centers.

One of the most effective means used by the Ministry is to work with the traditional leaders in a community to support the health assistants. When the Ministry informs the traditional leaders about community outreach activities, the traditional leaders will take the initiative to inform all the people in their own areas about preventive and PHC activities. Transportation to and from these communities remains a barrier. This is because not all the households have access to a phone. Therefore it is necessary for nurses to use vehicles to seek family members who must be seen by a doctor. In the outer atolls, messages are often passed on to the health assistant in order to reach the families through the radio communication system.

3.1.2.4 Population-Based Services

The Ministry of Health & Environment does not have the capabilities to conduct the following criteria: newborn screening for hearing, lead screening, and Sudden Infant Death Syndrome counseling. The two hospitals provide primary and secondary care and very limited tertiary care.

Having statewide outreach programs with community support and involvement is the ultimate goal for the Ministry. People in the communities have to take the initiatives to improve the health status in their own communities. Community Health Councils (CHC) have been established in 48 of the communities. Selected members of the CHC are brought in for training to have a better understanding of the preventive services, how they can access these services, and what the communities can do to improve health situation in their own communities. During these training sessions the CHC members learn about nutrition, breast feeding, immunization, family planning, TB/leprosy, diabetes, pre- and postnatal care, diabetes prevention, water and sanitation and the significance of data collection for each of the programs presented.

When health teams and zonal nurses travel to the communities, preventive services and outreach programs are more successful because the traditional leaders and CHC members are involved in coordinating the activities in their own respective areas. Population-based services are at the community levels and much more effective this way. More training will be needed with the CHC to develop their own mechanisms to assess the needs for CSHCN in their communities.

3.1.2.5 Infrastructure Building Services

One of the main concerns for the Ministry is the need to improve the health information system. It has been shown that data and statistics for the RMI were either under reported or inaccurate. Underreporting affects core MCH programs and services since decisions in program management relies on data to evaluate our performances objectively. However, the data that we did have indicated that the MCH program did not achieve all the goals and objectives we have set despite the fact that funding was available to improve services for the MCH population. In FY 2001, the MOHE will continue the initiatives implemented throughout FY 1999 and 2000 aimed at developing measures to ensure that the Ministry is aware of the resources available and utilizes them to enhance its ability to collect the types of data that can be used to evaluate performance and assist in policy-making decisions.

In order to address underreporting and inaccurate data collection, the MOHE implemented its rolling Five-Year Health Plan to provide direction for the Ministry and the means to evaluate its goals and objectives at the end of the year. In addition, the Health Management Information System has been utilized to provide comprehensive and accurate data. The Health and Population Project was launched to improve the RMI's health infrastructure and PHC services where traditional leaders played a major role in the implementation of primary health care programs at the community levels, and the development of a Breast Feeding Policy to improve health of infants and mothers. The National Population Policy was approved by the Government to address the issues of population growth, IMR, teen

pregnancies, and other health indicators. The government also approved the Food and Agriculture Policy to address the issues of malnutrition in children, anemia in women and community awareness. The 18-month training program for female health assistants, initiated in 1996 to improve access to health care for women in the outer atolls, graduated its first class of female health assistants in February 1999. In 1998, the MOHE approved a change in fees for delivery whereby the pregnant women who attend prenatal care during first trimester pay a minimum of $5 for delivery in the hospital. Others pay a hospital delivery fee of $25 for attending prenatal care during second and third trimester. The Ministry will continue to develop means to address the needs of teenagers, women, infants and children and CSHCN.

3.2 Health Status Indicators

3.2.1 Priority Needs

Based on health data collected by the MCH Program, the RMI MCH/CSHCN has selected the same priority needs as last year's needs. These priority needs have been selected to improve the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid.

1. To reduce infant mortality rates.
2. To reduce the barriers to access prenatal care so women can have prenatal care during first trimester.
3. To increase access to preventive services for women who are at risk for cancer.
4. To improve health status of pregnant women through counseling on nutrition and breast feeding.
5. To strengthen the capabilities of Health Management Information System to provide essential data and statistics on how the Ministry can improve programs and services.
6. To improve accessibility to the MCH/CSHCN services for children 0-17 years and the coordination of services between agencies for CSHCN.
7. To improve preventive services for school children in dental care and nutrition.

3.3 Annual Budget and Budget Justification

A breakdown of the MCHBG is provided here according to the three components of the grant. Budget justification follows under 3.1.2.

Component A: Pregnant Women, Mothers and Infants: $ 181,562

A. Personnel	: $ 87,865
B. Fringe benefits	: $ 7,125
C. Travel	: $ 15,788
D. Equipment	: $ 43,334
E. Supplies	: $ 27,450

Component B: Children & Adolescents: $ 145,249

A. Personnel	: $ 43,673

B. Fringe benefits	: $ 3,540	
C. Travel	: $ 29,314	
D. Equipment	: $ 29,445	
E. Supplies	: $ 34,277	
F. Contractual serv.	: $ 4,200	
G. Others	: $ 800	
Component C: Children with Special Health Care Needs:		$ 72,625
A. Personnel	: $ 33,045	
B. Fringe benefits	: $ 2,644	
C. Travel	: $ 23,677	
D. Equipment	: $ 3,600	
E. Supplies	: $ 5,659	
F. Contractual	: $ 4,000	
Administrative Cost		$ 25,208
MCH Budget (State Federal Allocation)		$ 181,562
MCH Budget (Federal and State Block Grant Partnership)		$ 423,644
Total budget for FY 2001		$ 1,612,368

3.3.1 Completion of Budget Forms

Detailed budget breakdowns are found in Forms 2, 3, 4, and 5

3.3.2 Other Requirements

For the FY 2001 budget, 42% is for salaries of personnel who provide direct services for the MCH/CSHCN program. There are 10 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provide direct health care services to the MCH population as well.

Although travel costs allocated account for 16% of the total budget for FY 2001, this allocation supports the goals of the Ministry to improve preventive and primary health care services for the targeted outer island population in MCH. Traveling within the Marshall Islands is necessary for personnel to provide health care services in support of the health assistants in the health centers. Furthermore, the identified CSHCN will need to travel to and from their own islands to the urban center for follow-up and further treatment and follow-up to Honolulu Shriners' Children Hospital if necessary.

State Match

The total for the MCHBG application for the FY 2000 is $423,644. This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is $ 181,562.

Documentation of Fiscal Restrictions

The Republic of the Marshall Islands assures the Secretary of Health and Human Services that no more than 10% of the Title V funds will be used for administrative cost for the MCH Block Grant. The total amount will be used by the MOHE Administration to: 1) attend meetings that are conducted by the MCH Bureau and other agencies with regards to the MCH Programs and Services, 2) purchase supplies that are needed for administrative support of the MCH services such as office supplies, stamps, and other means to support communication between the funding agencies and the MOHE, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MOHE Administration.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

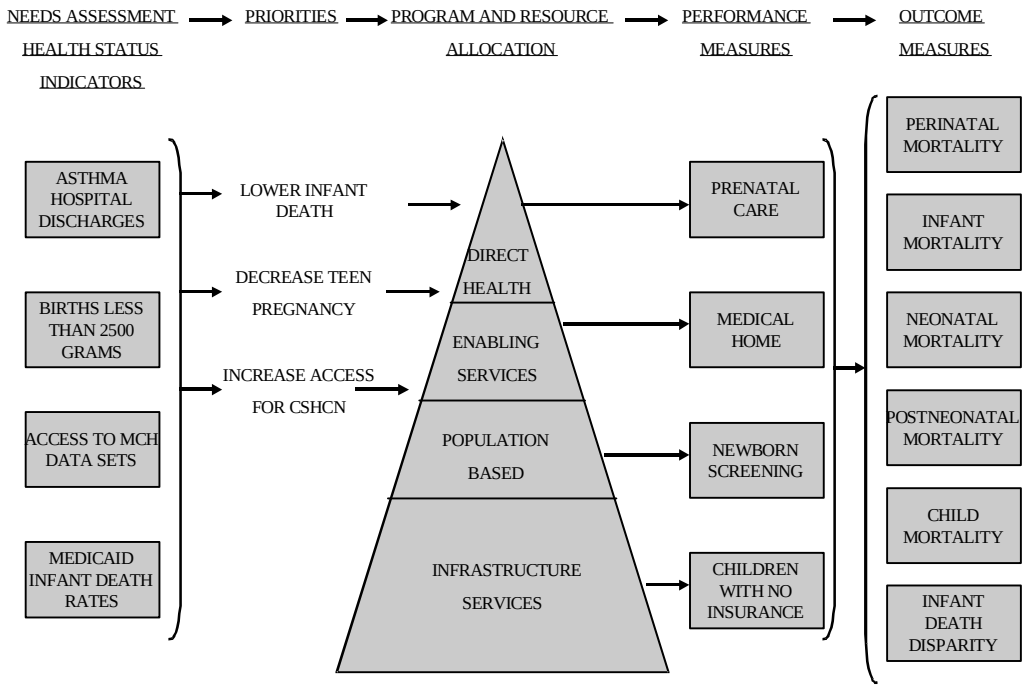


Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1. The percent of pregnant women who receive counseling on nutrition and family planning during prenatal visits.				X		X	
2. The percent of pregnant women who have prenatal care during first trimester.	X						X
3. The percentage of children under 2 years old who have completed the basic immunization series.	X						X
4. Provide health education activities related to suicide geared towards the 15 to 19 year old age group.		X					X
5. The proportion of women who exclusively breast feed their infants up to six months and continue up to 2 years			X			X	
6. The proportion of children who are identified and referred to the CSHCN program.	X				X		
7. The number of women who are screened for cancer.			X			X	
8. The proportion of school children who receive preventive services in dental care.			X				X
9. The percent of high-risk pregnant women who are identified and are referred to special prenatal services				X			X
10. Increase the number of teenager (15-19) acceptors of modern contraception				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

Details on Form 11

The RMI MCH/CSHCN program will continue to provide services for infants, children, women, adolescents and children with special health care needs. The programs in the Bureau of Primary Health Care will target teenage mothers and those between ages 15-17 for the next five years.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

3.4.2.2 Discussion of State Performance Measures

Direct Health Services:

SPM2: Increase the percent of pregnant women who attend prenatal care during first trimester:* (DISCONTINUED*)

This measure was discontinued since it duplicates a national Performance Measure. *The number of neonatal deaths and low birth weight babies has increased over the past two years. In 1996, the IMR for the RMI was estimated at 26 per 1,000 live births. In 1997, the IMR has increased to 30 per 1,000 live births. Additionally, the number of neonatal deaths increased to 20 per 1,000 live births. Ebeye Island had the highest rate of 41.67%. The perinatal death was 14 per 1,000 live birth and prematurity was the main cause of death. For all the perinatal deaths none of the mothers attended prenatal care. In*

order to decrease the IMR and the perinatal death, it is necessary for the RMI to intensify its health promotion and educational program to ensure women do have access to prenatal care. The female health assistant training program will be completed at the end of the year, and more women will access prenatal care in the health centers. The public health clinics will need to be reorganized for close follow-up with pregnant women and those who are referred from the communities to the clinics.

SPM3: Increase the percentage of children under 2 years old who have completed the basic immunization series.* (DISCONTINUED*)

This measure was discontinued since it duplicates a national Performance Measure. *The RMI immunization coverage was always low. With the introduction of the zoning and community based PHC services, the RMI would like to continue to increase its immunization coverage rate. In 1995, the coverage rate was lower than 50%. In 1996, the rate was increased to 50% and 1997 was 75%. The RMI has a very dispersed population where access to immunization program is limited to the outer island children. The Ministry has the challenge to strengthen its capabilities to improve the immunization programs throughout the RMI. In recent years, there were outbreaks of measles in our Pacific neighboring countries, and it is therefore imperative that the RMI continue to increase and expand its immunization programs.*

SPM6: Increase the number of children 0-3 who are identified to need special health care are referred to the CSHCN Program.

There are infants who are not been screened because there is a lack of mechanism for screening. The RMI developed a more comprehensive system to address the needs for children with special health care needs in the country. A referral system was developed to provide the health care services that these children and their families need. Health promotion, family support, health information system, and the development of a referral system are all essential to address the needs of children identified as CSHCN.

Enabling Services:

SPM4: Provide health education activities related to suicide prevention geared towards the 15 to 19 year old age group.

The RMI has one of the highest suicide rates in the Pacific. In 1995, the number of suicides was very high at 18. Although it has decreased in to only 1 in 1998 and 1999, there is still a great concern, since more than 42% of the Marshall Islands population is less than 18 years old. All the suicide victims were male and alcohol was involved in all the cases. The RMI needs to strengthen its programs and services in Alcohol and Substance Abuse Prevention programs, the Mental Health Program and increase community awareness in order to reduce the high rates of suicides among youths. It is imperative to develop a more comprehensive training program at the community levels to increase community awareness on suicide prevention. Training of youths and community leaders is essential to recognize the signs in contemplating suicide among youths in order to refer for services and necessary counseling. The Division of Human Services has included in its Action Plan to address suicides and targeting youths. Detecting those most likely to consider or attempt suicide in

youths will contribute to decreasing the likelihood of them attempting suicide in later years. This will be a big first step since most completed suicides occur in the 20 to 24 age range. Health education activities include expanding health promotion activities to include the Youth to Youth in Health organization, a non-governmental organization (NGO), that focuses on teens. In addition, pamphlets and other publications will be developed that target specific age groups. Other activities will also include providing training sessions to those clinicians to recognize and be able to provide interventions to those youth at high risk of attempting or contemplating suicide.

Infrastructure Building Services

SPM1: Increase the percent of mothers who receive nutrition and family planning counseling during prenatal visits.

The number of low birth weight babies has continued to increase as mentioned in SPM1 above. The RMI needs to improve its health education and nutrition counseling services during prenatal care and community outreach programs. In addition to nutrition counseling, the RMI will have to develop a mechanism for close follow-up and monitoring with the women who are identified as high risk during pregnancy. Family planning is included here as part of the prenatal care services to support the decrease of the annual growth rate, improve access to family planning and increase community awareness on family planning services as well. The MCH program is also developing a checklist of topics to be covered in counseling sessions with expectant mothers. This addition to the current protocol will ensure that all topics, including nutrition, are addressed and given similar attention.

SPM9: The percent of high-risk pregnant women who are identified and are referred to special prenatal services (NEW MEASURE)

This is a NEW measure. Mothers who are at high risk for complications during their pregnancy are often identified during their prenatal visits. The main objective of this State Performance Measure (SPM) is to identify those women who will need treatment (preventive or curative) in addition to the services already offered in the prenatal clinics. Similar to SPM 1, counseling services will be offered on nutrition and family planning. However, SPM 9 aims to extend counseling to include other areas such as immunization, diet, diabetes, and hypertension. The MCH program will also use these sessions to update the women's immunization status (if needed), conduct self breast examinations and training, STD screening, diabetes and hypertension screening, and how to take care of her infant. The staff will be trained to explain the reasoning behind the services we provide and how it will help her and her family. Ideally, women who are at high risk are identified before they are pregnant. However, prenatal care visits (1,421 total first and return visits in 1999) provide the best means for the MCH program to reach as many women as possible.

SM10: Percentage of new teenage (15 to 19) acceptors of modern contraception (NEW MEASURE)

This is a NEW measure. Teenagers 15 to 19 account for approximately 15% (<15 account for 0.2%) of the total number of visits to Family Planning in 1998. However, there

are no reliable data on the number of teenage *users* of modern contraception. Studies have shown that teens are the least ready or prepared to have babies yet most unplanned pregnancies occur to teens. In addition, LBW and premature babies are often seen in teenage mothers. This SPM aims to set a baseline in which all future measures for family planning acceptors and users will be based. One of the challenges will be to develop culturally sensitive and logically feasible ways to promote family planning methods.

Population Based Services

SPM5: Increase the percent of women who exclusively breast feed their infants during the first six months and continue for up to two years.

The RMI MOHE has developed a Breast Feeding Policy that became effective in 1996. The Breast Feeding Policy is for all the health facilities including health centers to have all babies born in any health facilities to be exclusively breast fed upon discharge. The BF Policy does not allow families to bring in baby bottles in the hospitals. Breast-feeding has become a national priority because of the goal to reduce IMR and other nutritional deficiencies in the country. In collaboration with the UNICEF, the RMI ahs already implemented steps necessary to become a Baby Friendly Hospital as part of the goal of UNICF under *Baby Friendly Hospital Initiative* (BFHI). Training of staff in all areas in the Ministry using the 18-Hour Breast Feeding Manual started in 1996. Training was necessary in order to have staff in the Ministry understand the MOHE Breast Feeding Policy and to support community awareness on breast-feeding. Breast feeding of infants during the first six months of live will contribute immensely to the reduction of IMR and the RMI. The MOHE developing a mechanism to evaluate and monitor the rate of breast feeding after hospital discharge.

SPM7: Increase the proportion of women who are screened for cervical cancer.

Another area of great concern is the lack of Pap smear provided for all women. The clinics in Public Health do not provide Pap smear to all women who come to the clinics. The women living in the outer islands also lack accessibility to Pap smear screening. When health teams travel to outer atolls, sometimes Pap smear is provided, other times not. Thus women are at risk for developing cancer without knowing it. The women who died had learned about their cancer too late. The RMI needs to restructure its health care system to address the needs for health care services for women in the RMI. The prevalence rate of cancer in the country is high in comparison to other Pacific countries. Having a women's health clinic established is a priority for RMI. The Ministry would like to establish a comprehensive health care program for women. Such program will include access to Pap smear, close follow-up and monitoring, treatment and community awareness on preventive services for women.

SPM8: Improve dental health care services for school children. **(DISCONTINUED)**

This measure was discontinued since there were not enough dental available.

3.4.2.3 Five Year Performance Objectives

3.4.2.4 Review of State Performance Measures

The review of the RMI State Performance Measures will be submitted to the MOHE Technical Committee for the Health and Population Project, senior managers, division directors in the Bureau Primary Health Care for review and comments. During the training sessions for the Community Health Councils, the State Performance Measures will be presented to the member of the CHC for the review and comments. Announcement will be made to the public for their input and review if interested.

3.4.3 Outcome Measures

State Outcome Measures were not selected since the National Outcome Measures were sufficient.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

Director Health Care Services: The RMI will continue to focus its preventive and health care services for pregnant women, mothers, infants and children and CSHCN in the country. These health care services will be provided in the two hospitals, health centers in the outer atolls, Public Health clinics and during our community outreach programs and activities.

Enabling Services: MCH/CSHCN will continue to collaborate with the Health Education and Nutrition Unit and Public Health Programs in conducting its community outreach and health promotion activities for women, children, pregnant women and infants both in the urban centers and the remote atolls.

Population-Based Services: The MCH/CSHCN program will strengthen its screening efforts to provide Pap smear to all women who attend the Public Health clinics and those who are at risk for developing cervical cancer. This will be done in the clinics as well as during community outreach activities. The MCH/CSHCN will improve its screening efforts for children with special health care needs in addition to the coordination and referral to the CSHCN program. Additionally, the RMI will improve its dental health care services and school health programs, which will include immunization, Vitamin A distribution, and fluoride distribution, for the school children. Community outreach will continue to develop its primary health care programs to provide immunization, screening and health promotion at the community levels.

Performance Measure 1: The percent of State SSI beneficiaries less than 16 year old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN). This performance is not relevant to the RMI since there is no SSI program.

Performance Measure 2: The degrees to which the State Children with Special Health Care Needs program provides or pays specialty and subspecialty services including care coordination, not otherwise accessible or affordable to its clients.
2001 Annual Performance Objective: 9
Planned Activities: There will be no change in this performance measure. The RMI will continue to improve its services in the 8 categories even with limited services available on island. The RMI will

continue to strengthen its services in medical and surgical subspecialty services, outpatient services, home health care, nutrition services, care coordination, and speech, hearing and language services. More activities will be focused on Early intervention. Medical referral services will continue for those children needing specialized medical care.

Performance Measure 3: The percent of CSHCN in the State who have a "medical or health home"

2001 Annual Performance Objective: 100%

Planned Activities: The MOHE being the "state" health agency, provides medical health care services to all residents through the State Hospitals on Majuro and Ebeye in the Public Health. Infants and children who are identified are referred to the pediatricians or the physician who is on call who will become the primary physician for the referred cases. The MCH/SCHCN program will continue to collaborate with medical staff in the hospitals in providing health services to all infants and children. Every child in the RMI is considered as having a "medial/health home".

Performance Measure 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies combined.

This National Performance Measure is not applicable to the RMI since metabolic screening is not performed.

Performance Measure 5: Percent of children through age 2 who have completed immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemphius Influenza, Hepatitis B.

2001 Annual Performance Objective: 85%

Planned Activities: The RMI will continue to intensify its immunization coverage rate during community outreach activities. The nurses will work closely with the health assistants in the outer islands in sending out the vaccines for the children living in the outer islands and with health teams as well. Training of Community Health Council will enhance community support and awareness on the immunization program efforts. In addition, the zone nurses in the urban centers will continue their zoning activities by going house to house daily to provide needed services for infants and children. The CASA software developed by the CDC was installed in the Immunization Office in February 1999. Although the software is user-friendly, program managers still have to occasionally call the CDC for assistance. Beginning in 1999, the Immunization Program will begin to use hospital numbers to ensure the accuracy of the data.

Performance Measure 6: The birth rate (per 1,000) for teenagers aged 15 through 17.

2001 Annual Performance Objective: no more than 150 per 1,000 live births

Planned Activities: The RMI will focus its effort to decrease the rate of teenage pregnancies in the coming years by improving health education and promotion activities for youths, improving barriers that inhibit accessibility to family planning services for youths, and conduct training for community leaders on the issues presented in the National Population Policies. The teenage pregnancy rate for 1998 was 17.6% or 176 per 1000 live births, but this rate includes ages 15-19. It is estimated that the number of teen pregnancies might be higher in 1999. The 1999 Annual Performance Objective is not to exceed 150 per 1,000 live birth in order to reach 55 per 1,000 live birth by the year 2001. More activities on health promotion and family planning will target to meet the needs of youths in the RMI. The Youth to Youth in Health will establish youth clinics in the rural areas in the urban centers and more youth chapters in the outer atolls in collaboration with the Community Health Councils.

Performance Measure 7: The percent of third grade children who have received protective sealant on at least one permanent molar tooth.
2001 Annual Performance Objective: 95% of the proportion of children ages 8 and 14.
Planned Activities: The School Sealant Program was not implemented in 1996, 1997, and again in 1998 due to the limited number of staff in the Division of Dental Services. The staff in the Dental Services already started the School Sealant program for 1998-99 school year but was unable to continue. The staff visited most of the elementary schools on Majuro totaling approximately 6,000 students in the public and elementary schools. As part of the school sealant program, staff performed dental education for the elementary schools that they visit during the year. The School Sealant program has not been implemented in the outer atolls.

Performance Measure 8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.
2001 Performance Objective: no more than 5 per 100,000
Planned Activities: The RMI has been able to keep the rates of children at this age group at zero for death caused by motor vehicles until 1998. Our health education and promotion activities will continue to address this issue to ensure that no deaths caused by motor vehicle crashes occur.

Performance Measure 9: Percentage of mothers who breast-feed their infants at hospital discharge.
2001 Performance Objective: 95%
Planned Activities: The MCH in collaboration with the Health Education and Promotion Unit, Core Committee and the Breast Feeding Policy Committee will develop educational materials, provide nutrition counseling during prenatal clinics, conduct presentations during prenatal clinics, postpartum clinics and at the maternity ward with mothers, and continue health promotion outreach in the communities and through mass media. Breast Feeding policy will be discussed with members of the Community Health Councils during community outreach and during training in the urban center. Staff in the Health Education will continue to discuss breast feeding on the weekly HE radio program.

Performance Measure 10: This performance measure is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals.

Performance Measure 11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care (Capacity).
2001 Performance Objective: 0%
Planned Activities: There is universal health care coverage for all citizens and residents in the RMI. The Ministry will focus on efforts to screen all children in order to have the children identified with special health care needs and refer them to the CSHCN program.

Performance Measure 12: Percent of children without insurance.
2001 Performance Objective: 0%
Planned Activities: See Performance Measure 11.

Performance Measure 13: This performance measure is not applicable to the RMI because the RMI is not eligible for the Medicaid Program.

Performance Measure 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.
2001 Performance Objective: 10
Planned Activities: The RMI scored an 8 in this particular measure in 1998. The MCH/CSHCN program will continue to improve its efforts to conduct follow-up visits with parents and families of those CSHCN. The Core Committee will develop plans for the CSHCN and their families to learn more about the MCH programs and services. Similar activities will be implemented for the Community Health Councils during training and community outreach for close follow-up with clients and for community awareness on MCH programs and services.

Performance Measure 15: Percent of very low birth weight births.
2001 Performance Objective: 0%
Planned Activities: The MCH/CSHCN program, in collaboration with all programs in the Bureau of Primary Health Care, will develop educational materials on MCH, utilize mass media, community outreach, training for community awareness on MCH. Nutrition counseling will be provided during prenatal care, and close monitoring of high risk pregnant mothers will be implemented with the zonal nurses. The objective is not to increase the percent of low birth weight births.

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15-19.
2001 Performance Objective: 20%
Planned Activities: The MCH program will collaborate with the Division of Human Services to follow-up with participants of the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. The Health Education and the program on Alcohol and Substance Abuse Prevention will collaborate to conduct training with youths, community groups. Educational materials will be developed and the mass media will be utilized to air radio spots, radio programs and interviews on alcohol, substance abuse and suicides. Close monitoring and evaluation of the rates of suicides in each community will be implemented throughout the year in order to meet the needs of each community.

Performance Measure 17: This particular measure is not applicable since there are no health facilities for high-risk deliveries and care management in the RMI.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
2001 Performance Measure: 40%
Planned Activities: The Health Education and Promotion Unit in collaboration with the zonal nurses and Core Committee will intensify their health promotion activities on community awareness. Nurses will be doing a lot community outreach with the traditional leaders to follow-up with pregnant mothers at home who have not come in for prenatal care. The nurses will coordinate with the traditional leaders to inform their people to access prenatal care during first trimester. More educational campaigns will be implemented on the radio, TV and newspaper on prenatal care. The hospital will make the effort to inform the public about the fees for delivery for those mothers who attend prenatal care during first trimester as an incentive.

State Performance Measure 1: Percent of mothers who receive nutrition and family planning counseling during prenatal care.
2001 Performance Objective: 90%

Planned Activities: The nurses in Public Health will undertake in-service training in nutrition and family planning to be able to provide the counseling to all pregnant women who come to the prenatal clinics and the health zones. While it is anticipated that counseling on nutrition and family planning will not be provided to all pregnant women in the outer atolls because of the cultural barriers, plans are being developed to increase the coverage as much as possible. A protocol was implemented to ensure that pregnant women are counseled on nutrition and family planning. One person from health education will be designated to conduct counseling on nutrition and family planning for women referred from the prenatal clinic. Diabetes and hypertension will also be added to the counseling schedule. In addition, counseling will not be primarily limited to the first visit.

State Performance Measure 2: The percent of pregnant women who receive prenatal care during the first trimester.
This State Performance Measure was **discontinued** since it duplicates a national Performance Measure.

State Performance Measure 3: Percent of Children under 2 years who have completed basic immunization series.
This State Performance Measure was **discontinued** since it duplicates a national Performance Measure.

State Performance Measure 4: Provide health education activities related to suicide prevention geared towards the 15 to 19 year old age group.
2001 Performance Objective: 25%
Planned Activities: Through the RMI Interagency Council, the MCH/CSHCN will continue to conduct training for community leaders in developing community-based preventive programs on suicide, alcohol and substance abuse prevention, and mental health. Such programs will strengthen the network between the Ministry of Health and other agencies such as the Department of Public Safety, Majuro Atoll Local Government, Ministry of Education, women's groups, and churches. Health Education will take the initiative to collaborate with the Human Services Programs in community outreach to target youths in the communities.

State Performance Measure 5: The percent of women who exclusively breast feed their infants during first six months and continues for up to two years.
2001 Performance Objective: 100%
Planned Activities: The RMI will continue to implement the 10 Steps to have the two hospitals become Baby Friendly Hospitals in collaboration with the UNICEF Baby Friendly Hospital Initiative. The MOHE Breast Feeding Committee will monitor the activities in the Breast Feeding Policy to implement the policies in all health facilities in the RMI. Training for Community Health Councils on the Breast Feeding Policy will be carried out throughout the year for full support of breast feeding, preventive services and primary health care services at the community levels. Health education and promotion will utilize the mass media to increase community awareness on breast-feeding and its impact on child health. Educational materials will be developed. Training of staff in the Ministry and other agencies will continue in order to provide nutrition counseling during prenatal care and in community outreach. In collaboration with the Nutrition Unit, breast-feeding support groups will be established in the urban center of Majuro.

State Performance Measure 6: The proportion of children 0-3 who are identified to need special health care are referred to the Children with Special Health Care Needs program.

2001 Performance Objective: Increase by 20%

Planned Activities: For 1998, there were 152 children identified and referred to the CSHCN program. Currently, there is no reliable baseline for the number of infants that were screened for CSHCN program. The MCH/CSHCN program will develop a mechanism to screen all infants born in the health facilities. Since there is currently no system in place to inform doctors, a protocol is being developed to handle those children seen in the MCH program and are referred to the hospital for further examination by the pediatrician. Training will be provided to all health care providers in the hospital, Public Health clinic, and in health centers on how to use the screening tool. Health teams who travel to the outer islands will provide support in the screening done in health centers and further refer cases to the urban centers if necessary. Zonal nurses will be trained to use the screening tool during community outreach and screening. Health education and Promotion Unit will be involved in this activity by developing public announcements, booklets, leaflets and posters about the services offered in the MCH/CSHCN program. The mass media will be utilized to disseminate information, which will also be distributed to the traditional leaders in each zone. Note that beginning in FY 2001, number of children will be recorded rather than proportion.

State Performance Measure 7: The number of women who are screened for cervical cancer.

2001 Performance Objective: Increase by 25%

Planned Activities: The MCH/SCHCN program will review its protocols on cancer screening particularly on cancer of the uterus and cervix. Pap smear screening will be implemented in all public health clinics, during outreach clinics and trips to the outer atolls. All necessary supplies will be purchased for the screening. A central registration system will be established to monitor results of the Pap smear and for close follow-up. All women will be told the result, whether positive or negative, of their Pap smear. The current practice is only to call women who have negative results or are required for another Pap smear. This system will be further used to establish a women's clinic to provide screening, counseling and other preventive services including family planning. Nurses in Public Health will implement the clinics. They will also refer patients from the zones to the clinic. Moreover, identified women who need follow-up will be referred to the zonal nurses for follow-up. The protocol on physical exams will also be revised to include Pap smears for adult women. This will include Pap smears to be performed for women in the outer islands. Note that beginning in FY 2001, number of women will be recorded rather than proportion.

State Performance Measure 8: The proportion of school children between ages 8 and 14 who receive dental services

This State Performance Measure was discontinued. There were plans to combine this program with current public health outreach activities like the eye/ear exams and the immunization programs. However, this has not been possible due to the lack of dental staff.

State Performance Measure 9: The percent of high-risk pregnant women who are identified and are referred to special prenatal services

2001 Annual Performance Measure: 40%

Planned Activities: The MCH/CSHCP will be working closely with the Health Education and Promotion Unit in developing educational materials that are essential for community awareness activities and training. These educational materials will include leaflets, posters, and booklets, which will be disseminated during community outreach programs. Additionally, the Health Education & Promotion Unit staff will utilize the weekly health education radio to discuss MCH issues and to develop radio spots. During training with Community Health Councils, the MCH and Health Education Staff will include plans and activities on health promotion. The nurses will also

work closely with the traditional leaders to help in informing all pregnant women to access prenatal care during first trimester.

State Performance Measure 10: Increase the number of teenager (15-19) acceptors of modern contraception

2001 Performance Objective: 20%

Planned Activities: As a first step to promoting family planning and increasing the number of modern contraception users, the MCH program will work closely with Family Planning, Health Education and Promotion office, and the Youth to Youth in Health program. A planning meeting will be conducted to plan out activities and coordinate with other public health outreach activities. Steps will also be taken to ensure that family planning and contraception is approached in a culturally sensitive way. Public health staff will also assist the MCH program staff in clinical activities and with the help and support of traditional leaders, community outreach activities.

4.2 Other Program Activities

The MCH/CSHCN Program is already a program area within Public Health. The nurses and medical staff in Public Health provide other preventive services in STD, family planning, non-communicable diseases, immunization, TB and leprosy as well. The MCH coordinator is member of the MOHE Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Interagency Council under a Memorandum of Understanding. The Interagency Council meets regularly to ensure continuous services is provided to all CSHCN, both in school and those who are not. The Breast Feeding Policy Committee also actively work closely with the MCH program and services in community awareness activities on nutrition and breast-feeding. The MCH program will participate fully in all community awareness and training programs to improved preventive services to women, children, infants, youths and their families.

4.3 Public Input [Section 505(a)(5)(F)]

The Ministry will make more effort to have the public be more involved in the MCH programs and reviewing the grant application. Each year public announcements are made for the public to attend such meeting, but not too many people are interested. The last public meeting conducted was in July 1997. With the Community Health Councils established, the MOHE will coordinate with them for meeting schedule with communities for input and comments on the MCH programs and services.

4.4 Technical Assistance [Section 509 (a)(4)]

The MCH/CSHCN program will need TA in the areas specified in the Form 15. There are weaknesses in the area of Needs Assessment, Data System Development and Performance Indicators. TA is also essential in the evaluation of the CSHCN to ensure services provided and mechanisms for screening are implemented.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength

of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated

technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the

Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adquecy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance

measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH

dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

Needs Assessment Status and Update January 2001

Purpose:

The purpose of the Maternal and Child Health (MCH) Needs Assessment are as follows:

1. To provide a baseline and updated data for defining and redefining policy and future direction for MCH.
2. To provide a baseline and updated data for planning and allocating MCH resources.

Objectives:

The objectives of the MCH Needs Assessment are as follows:

1. To provide information and data to plan and implement services and programs that address local needs.
2. To identify the following:

    A. Duplication, gaps, and under-utilization in/of services.
    B. Access barriers that clients encounter.
    C. Issues and activities where technical assistance and consultation is needed.
    D. Issues that require policy development.

3. To determine roles and responsibilities of MCH.
4. To recommend strategies for assuring service availability and appropriate services delivery systems exist.
5. To acknowledge providers national impact on meeting local and national goals and objectives.

Methodology:

Phase I: Organization of the planning project.

This phase includes establishing the purpose of the project, determining desired outcomes, assigning staff and defining roles.

Phase II: Data collection:

The second phase is the collection of the information to set the scope and help prioritize the issues. The expertise and knowledge of ministry staff will be utilized to provide information about the positive aspects of the current service delivery system, what areas need improvement or change, and the desired outcomes from providing family-centered, community-based, coordinated services to children with special health care needs and their families. Initial data collection activities have revealed areas of weaknesses within the ministry's data management. One of the areas identified is on data management for the vertical public health programs in the Division of Public Health. A standardized form

has been developed as part of a comprehensive plan to combine all the vertical programs under one database

Phase III: Briefing Paper and Draft Report:

A briefing paper, comprising reports from all pertinent programs in the ministry, that examines the prioritized needs in detail has been developed. This briefing paper was submitted for review in January 2000. The paper contains the criteria set out under Healthy People 2000 and Healthy People 2010. The main task of the planning group is to select those performance indicators and measures that are relevant to the Marshall Islands. The practicality of introducing new data sets that that are not included in the current database will be introduced.

Phase IV: Draft Report:

One paper will be compiled to ensure that it is as comprehensive as possible. This draft report will be submitted by **March 1, 2001.**

Phase V: Final Report:

The completion of a report, which includes input from key program directors and managers responsible for areas related to maternal and child health, will be written. Determination of needs requires a value judgement. The identification of needs is a process of describing and prioritizing the problems of the target population and recognizing potential solutions to those identified problems. This report will be submitted with the FY 2002 MCH Block Grant application due **July 15, 2001**.

Phase VI: Strategic Plan:

The development of a strategic plan for implementing necessary service changes or improvements as determined by the Needs Assessment. The process for developing the strategic plan will be dependent upon the results of the previous phases. The following will be taken into consideration in the final report:

- Normative Need - derived from expert opinions about appropriate levels of service or health status or standards (i.e. Healthy People 2000 objectives)
- Perceived Need - derived from the expectations of the population.
- Expressed Need - defined through the utilization of services.
- Relative Need - derived from examination of the equity of distribution of services across populations.